



MEMBERSHIP
MOVES
MEDICINE™

HOUSE OF DELEGATES HANDBOOK

2018 INTERIM MEETING

Gaylord National Resort & Convention Center, National Harbor, Md.
Nov. 10–13



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Visit ama-assn.org/hod-interim-handbook to access the handbook online.

MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

- **All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items to be considered by the House.**
- **No action has been taken on anything herein contained, and it is informational only.**
- **Only those items that have been acted on finally by the House can be considered official.**
- **The Interim Meeting is focused on advocacy issues. A resolution committee (see AMA Bylaw 2.13.3) considers each resolution and recommends that the item be considered or not considered at the Interim Meeting. Items that meet the following definition of advocacy or that are considered urgent are recommended for acceptance:**

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

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

- **REMINDER: *Only the Resolve portions of the resolutions are considered by the House of Delegates. The Whereas portions or preambles are informational and explanatory only.***



UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

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

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

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

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

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

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

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

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

5.000 Abortion	10.000 Accident Prevention/Unintentional Injuries
15.000 Accident Prevention: Motor Vehicles	20.000 Acquired Immunodeficiency Syndrome
25.000 Aging	30.000 Alcohol and Alcoholism
35.000 Allied Health Professions	40.000 Armed Forces
45.000 Aviation Medicine	50.000 Blood
55.000 Cancer	60.000 Children and Youth
65.000 Civil and Human Rights	70.000 Coding and Nomenclature
75.000 Contraception	80.000 Crime
85.000 Death and Vital Records	90.000 Disabled
95.000 Drug Abuse	100.000 Drugs
105.000 Drugs: Advertising	110.000 Drugs: Cost
115.000 Drugs: Labeling and Packaging	120.000 Drugs: Prescribing and Dispensing
125.000 Drugs: Substitution	130.000 Emergency Medical Services
135.000 Environmental Health	140.000 Ethics
145.000 Firearms: Safety and Regulation	150.000 Foods and Nutrition

155.000 Health Care Costs	160.000 Health Care Delivery
165.000 Health Care/System Reform	170.000 Health Education
175.000 Health Fraud	180.000 Health Insurance
185.000 Health Insurance: Benefits and Coverage	190.000 Health Insurance: Claim Forms and Claims Processing
195.000 Health Maintenance Organizations	200.000 Health Workforce
205.000 Health Planning	210.000 Home Health Services
215.000 Hospitals	220.000 Hospitals: Accreditation Standards
225.000 Hospitals: Medical Staff	230.000 Hospitals: Medical Staff - Credentialing and Privileges
235.000 Hospitals: Medical Staff - Organization	240.000 Hospitals: Reimbursement
245.000 Infant Health	250.000 International Health
255.000 International Medical Graduates	260.000 Laboratories
265.000 Legal Medicine	270.000 Legislation and Regulation
275.000 Licensure and Discipline	280.000 Long-Term Care
285.000 Managed Care	290.000 Medicaid and State Children's Health Insurance Programs
295.000 Medical Education	300.000 Medical Education: Continuing
305.000 Medical Education: Financing and Support	310.000 Medical Education: Graduate
315.000 Medical Records and Patient Privacy	320.000 Medical Review
330.000 Medicare	335.000 Medicare: Carrier Review
340.000 Medicare: PRO	345.000 Mental Health
350.000 Minorities	355.000 National Practitioner Data Bank
360.000 Nurses and Nursing	365.000 Occupational Health
370.000 Organ Donation and Transplantation	373.000 Patients
375.000 Peer Review	380.000 Physician Fees
383.000 Physician Negotiation	385.000 Physician Payment
390.000 Physician Payment: Medicare	400.000 Physician Payment: Medicare - RBRVS
405.000 Physicians	406.000 Physician-Specific Health Care Data
410.000 Practice Parameters	415.000 Preferred Provider Arrangements
420.000 Pregnancy and Childbirth	425.000 Preventive Medicine
430.000 Prisons	435.000 Professional Liability
440.000 Public Health	445.000 Public Relations
450.000 Quality of Care	455.000 Radiation and Radiology
460.000 Research	465.000 Rural Health
470.000 Sports and Physical Fitness	475.000 Surgery
478.000 Technology - Computer	480.000 Technology - Medical
485.000 Television	490.000 Tobacco Use, Prevention and Cessation
495.000 Tobacco Products	500.000 Tobacco: AMA Corporate Policies and Activities
505.000 Tobacco: Federal and International Policies	510.000 Veterans Medical Care
515.000 Violence and Abuse	520.000 War
525.000 Women	600.000 Governance: AMA House of Delegates
605.000 Governance: AMA Board of Trustees and Officers	610.000 Governance: Nominations, Elections, and Appointments
615.000 Governance: AMA Councils, Sections, and Committees	620.000 Governance: Federation of Medicine
625.000 Governance: Strategic Planning	630.000 Governance: AMA Administration and Programs
635.000 Governance: Membership	640.000 Governance: Advocacy and Political Action

LIST OF MATERIAL INCLUDED IN THIS HANDBOOK (I-18)

Resolutions and reports have been collated by referral according to reference committee assignment. In the listing below, referral is indicated by letter in parenthesis following the title of the report. Resolutions have been numbered according to referrals (i.e., those referred to the Reference Committee on Amendments to Constitution and Bylaws begin with 001, Reference Committee B begins with 201, etc.).

The informational reports contain no recommendations and will be filed on Sunday, November 11, unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

- 1. Memorandum from the Speaker**
- 2. Understanding the Recording of American Medical Association Policy**
- 3. Declaration of Professional Responsibility - Medicine's Social Contract with Humanity**
- 4. Delegate / Alternate Delegate Job Description, Roles and Responsibilities**
- 5. Seating Allocation and Seating Chart for the House of Delegates**
- 6. Hotel Maps**
- 7. Official Call to the Officers and Members of the AMA**
 - Listing of Delegates and Alternate Delegates**
 - Officials of the Association and AMA Councils**
 - House of Delegates Reference Committee Members**
- 8. Note on Order of Business**
- 9. Summary of Fiscal Notes**

FOLLOWING COLLATED BY REFERRAL

- 10. Report(s) of the Board of Trustees - Jack Resneck, Jr., MD, Chair**
 - 01 Data Used to Apportion Delegates (F)
 - 02 Redefining AMA's Position on ACA and Healthcare Reform (Info. Report)
 - 03 2018 AMA Advocacy Efforts (Info. Report)
 - 04 Increased Use of Body-Worn Cameras by Law Enforcement Officers (B)
 - 05 Exclusive State Control of Methadone Clinics (B)
 - 06 Update on TruthinRx Grassroots Campaign (Info. Report)
 - 07 Advocacy for Seamless Interface Between Physicians Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs (B)
 - 08 340B Drug Discount Program (B)
 - 09 Hospital Closures and Physician Credentialing (J)
 - 10 Training Physicians in the Art of Public Forum (F)
 - 11 Violence Prevention (B)
 - 12 Information Regarding Animal-Derived Medications (K)
 - 13 2019 Strategic Plan (Info. Report)

14 Protection of Physician Freedom of Speech (Amendments to C&B)

11. Report(s) of the Council on Ethical and Judicial Affairs - James E. Sabin, MD, Chair

- 01* Competence, Self-Assessment and Self-Awareness (Amendments to C&B)
- 02* Study Aid-in-Dying as End-of-Life Option / The Need to Distinguish "Physician-Assisted Suicide" and "Aid-in-Dying" (Amendments to C&B)
- 03* Amendment to E-2.2.1, "Pediatric Decision Making" (Amendments to C&B)
- 04* CEJA Role in Implementing H-140.837, "Anti-Harassment Policy" (Amendments to C&B)
- 05* Physicians' Freedom of Speech (Amendments to C&B)

12. Opinion(s) of the Council on Ethical and Judicial Affairs - James E. Sabin, MD, Chair

- 01 Medical Tourism (Info. Report)
- 02 Expanded Access to Investigational Therapies (Info. Report)
- 03* Mergers of Secular and Religiously Affiliated Health Care Institutions - CORRECTED (Info. Report)

13. Report(s) of the Council on Long Range Planning and Development - Alfred Herzog, MD, Chair

- 01 Women Physicians Section Five-Year Review (F)

14. Report(s) of the Council on Medical Education - Carol D. Berkowitz, MD, Chair

- 01 Competency of Senior Physicians (C)
- 02 Review of AMA Educational Offerings (Info. Report)
- 03 Developing Physician-Led Public Health / Population Health Capacity in Rural Communities (C)
- 04 Reconciliation of AMA Policy on Primary Care Workforce (C)
- 05* Reconciliation of AMA Policy on Medical Student Debt (C)
- 06 Reconciliation of AMA Policy on Resident/Fellow Contracts and Duty Hours (C)
- 07 50th Anniversary of the AMA Physicians' Recognition Award and Credit System (Info. Report)
- 08 Study of Medical Student, Resident and Physician Suicide (Info. Report)

15. Report(s) of the Council on Medical Service - James G. Hinsdale, MD, Chair

- 01 Prescription Drug Importation for Personal Use (J)
- 02 Air Ambulance Regulations and Payments (J)
- 03* Sustain Patient-Centered Medical Home Practices (J)
- 04 The Site-of-Service Differential (J)

16. Report(s) of the Council on Science and Public Health - Robyn F. Chatman, MD, Chair

- 01* Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (K)
- 02* FDA Expedited Review Programs and Processes (K)

17. Report(s) of the HOD Committee on Compensation of the Officers - Marta J. Van Beek, MD, Chair

- 01* Report of the House of Delegates Committee on Compensation of the Officers (F)

18. Joint Report(s)

- CMS-CSAPH 01* Aligning Clinical and Financial Incentives for High-Value Care (J)

19. Report(s) of the Speakers - Susan R. Bailey, MD, Speaker; Bruce A. Scott, MD, Vice Speaker

- 01 Recommendations for Policy Reconciliation (Info. Report)

20. Resolutions

- 001 Support of a National Registry for Advance Directives (Amendments to C&B)
- 002* Protecting the Integrity of Public Health Data Collection (Amendments to C&B)

003* Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children (Amendments to C&B)

201 Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application (B)

202 Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings (B)

203 Support for the Development and Distribution of HIPAA-Compliant Communication Technologies (B)

204 Restriction on IMG Moonlighting (B)

205 Legalization of the Deferred Action for Legal Childhood Arrival (DALCA) (B)

206 Repealing Potential Penalties Associated with MIPS (B)

207 Defense of Affirmative Action (B)

208 Increasing Access to Broadband Internet to Reduce Health Disparities (B)

209 Sexual Assault Education and Prevention in Public Schools (B)

210 Forced Organ Harvesting for Transplantation (B)

211 Eliminating Barriers to Automated External Defibrillator Use (B)

212 Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings (B)

213 Increasing Firearm Safety to Prevent Accidental Child Deaths (B)

214 A Public Health Case for Firearm Regulation (B)

215* Extending the Medical Home to Meet Families Wherever They Go (B)

216* Medicare Part B Competitive Acquisition Program (CAP) (B)

217* Opposition to Medicare Part B to Part D Changes (B)

218* Alternatives to Tort for Medical Liability (B)

219* Promotion and Education of Breastfeeding (B)

220* Supporting Mental Health Training Programs for Corrections Officers and Crisis Intervention Teams for Law Enforcement (B)

221* Regulatory Relief from Burdensome CMS "HPI" EHR Requirements (B)

222* Patient Privacy Invasion by the Submission of Fully Identified Quality Measure Data to CMS (B)

223* Permanent Reauthorization of the State Children's Health Insurance Program (B)

224* Fairness in the Centers for Medicare and Medicaid Services Authorized Quality Improvement Organization's (QIO) Medical Care Review Process (B)

225* Surprise Out of Network Bills (B)

226* Support for Interoperability of Clinical Data (B)

227* CMS Proposal to Consolidate Evaluation and Management Services (B)

603* Support of AAIP's Desired Qualifications for Indian Health Service Director (F)

801 Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle (J)

802 Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk) (J)

803 Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of "Dense Breasts" on Mammogram (J)

804 Arbitrary Documentation Requirements for Outpatient Services (J)

805 Prompt Pay (J)

806* Telemedicine Models and Access to Care in Post-Acute and Long-Term Care (J)

807* Emergency Department Copayments for Medicaid Beneficiaries (J)

808* The Improper Use of Beers or Similar Criteria and Third-Party Payer Compliance Activities (H-185.940) (J)

- 809* Medicaid Clinical Trials Coverage (J)
- 810* Medicare Advantage Step Therapy (J)
- 811* Infertility Benefits for Active-Duty Military Personnel (J)
- 812* ICD Code for Patient Harm from Payer Interference (J)
- 813* Direct Primary Care Health Savings Account Clarification (J)
- 814* Prior Authorization Relief in Medicare Advantage Plans (J)
- 815* Uncompensated Physician Labor (J)
- 816* Medicare Advantage Plan Inadequacies (J)
- 817* Increase Reimbursement for Psychiatric Services (J)
- 818* Drug Pricing Transparency (J)
- 819* Medicare Reimbursement Formula for Oncologists Administering Drugs (J)
- 820* Ensuring Quality Health Care for Our Veterans (J)
- 821* Direct Primary Care and Concierge Medicine Based Practices (J)
- 901 Support for Preregistration in Biomedical Research (K)
- 902 Increasing Patient Access to Sexual Assault Nurse Examiners (K)
- 903 Regulating Front-of-Package Labels on Food Products (K)
- 904 Support for Continued 9-1-1 Modernization and the National Implementation of Text-to-911 Service (K)
- 905 Support Offering HIV Post Exposure Prophylaxis to all Survivors of Sexual Assault (K)
- 906 Increased Access to Identification Cards for the Homeless Population (K)
- 908 Increasing Accessibility to Incontinence Products (K)
- 911 Regulating Tattoo and Permanent Makeup Inks (K)
- 912 Comprehensive Breast Cancer Treatment (K)
- 913 Addressing the Public Health Implications of Pornography (K)
- 914 Common Sense Strategy for Tobacco Control and Harm Reduction (K)
- 915* Mandatory Reporting (K)
- 916* Ban on Tobacco Flavoring Agents with Respiratory Toxicity (K)
- 917* Protect and Maintain the Clean Air Act (K)
- 918* Allergen Labeling on Food Packaging (K)
- 919* Opioid Mitigation (K)
- 920* Continued Support for Federal Vaccination Funding (K)
- 921* Food Environments and Challenges Accessing Healthy Food (K)
- 951 Prevention of Physician and Medical Student Suicide (C)
- 952 IMG Section Member Representation on Committees/Task Forces/Councils (C)
- 953 Support for the Income-Driven Repayment Plans (C)
- 954 VHA GME Funding (C)
- 955 Equality for COMLEX and USMLE (C)
- 956 Increasing Rural Rotations During Residency (C)
- 957 Board Certifying Bodies (C)
- 958* National Health Service Corps Eligibility (C)
- 959* Physician and Medical Student Mental Health and Suicide (C)
- 960* Inadequate Residency Slots (C)
- 961* Protect Physician-Led Medical Education (C)
- 962* Improve Physician Health Programs (C)

21. Resolutions not for consideration

- 601 Creation of an AMA Election Reform Committee (Not for consideration)

602* AMA Policy Statement with Editorials (Not for consideration)

907 Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing (Not for consideration)

909 Use of Person-Centered Language (Not for consideration)

910 Shade Structures in Public and Private Planning and Zoning Matters (Not for consideration)

* contained in the Handbook Addendum

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

Preamble

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

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

Declaration

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

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

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

Adopted by the House of Delegates of the American Medical Association
in San Francisco, California on December 4, 2001

Delegate/Alternate Delegate Job Description, Roles and Responsibilities

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

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

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

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

A. Qualifications

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

B. Responsibilities

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

SEATING ALLOCATION – 2018 INTERIM MEETING

AMGA - 3
American Medical Group Association (AMGA) - 3

ANESTHESIOLOGY - 9
American Society of Anesthesiologists (ASA) - 9
Trustee (McDade) - 1
Former Board Chair (Patchin) - 1
Delegates - 6
Resident and Fellow Section Delegate - 1

ARS – 1
American Rhinologic Society (ARS) - 1

CARDIOLOGY - 11
American College of Cardiology (ACC) - 7
Delegates - 6
Resident and Fellow Section Delegate - 1
American Society of Echocardiography (ASE) - 2
Heart Rhythm Society (HRS) - 1
Society for Cardiovascular Angiography and Interventions (SCAI) - 1

CHEST PHYSICIANS - 3
American College of Chest Physicians (CHEST) (ACCP) - 3

CRITICAL CARE MEDICINE- 3
Society of Critical Care Medicine (SCCM) - 3
Delegates - 2
Resident and Fellow Section Delegate - 1

DERMATOLOGY - 8
American Academy of Dermatology (AAD) - 3
American College of Mohs Surgery (ACMS) - 1
American Society for Dermatologic Surgery (ASDS) - 2
American Society of Dermatopathology (ASD) - 1
Society for Investigative Dermatology (SID) - 1

EMERGENCY MEDICINE - 8
American College of Emergency Physicians (ACEP) - 8
Former President (Stack) - 1
Delegates - 7

ENDOCRINOLOGY - 3
American Soc for Reproductive Medicine (ASRM) - 1
The Endocrine Society (ES) - 2

FAMILY PHYSICIANS - 19
American Academy of Family Physicians (AAFP) - 19
Former Board Chair (Langston) - 1
Delegates - 18

GASTROENTEROLOGY - 6
American College of Gastroenterology (ACG) - 2
American Gastroenterological Association (AGA) - 2
American Society for Gastrointestinal Endoscopy (ASGE) - 2

GREAT LAKES - 106
Illinois - 20
Trustee (Kobler) - 1
Delegates - 11
Medical Student Regional Delegate- 1
American Acad of Facial Plastic and Reconstructive Surgery (AAFPRS) - 1
American College of Legal Medicine (ACLM) - 1
American Coll of Radiation Oncology (ACRO) - 1
American Med Women’s Association (AMWA) - 1
American Society for Metabolic and Bariatric Surgery (ASMBS) - 1
North American Neuro-Ophthalmology Society (NANOS) - 1
Society of Nuclear Medicine and Molecular Imaging (SNMMI) - 1
Indiana - 7
Former Board Chair (Steen) - 1
Delegates - 5
Resident and Fellow Section Delegate - 1
Michigan - 17
Trustee (Mukkamala) - 1
Delegates - 12
Medical Student Regional Delegates - 1
American Roentgen Ray Society (ARRS) - 3
New York - 29
Former President (Nielsen) - 1
Former Board Chair (Cady) - 1
Delegates - 19
Medical Student Regional Delegates - 2
Resident and Fellow Section Delegate - 1
American College of Nuclear Medicine (ACNM) - 1
American Soc of Addiction Medicine (ASAM) - 1
American Society of Neuroradiology (ASN) - 1
Society of Interventional Radiology (SIR) - 2
Delegate - 1
Resident and Fellow Section Delegate - 1
Ohio - 15
Delegates - 11
Medical Student Regional Delegates - 2
Resident and Fellow Section Delegate - 1
Amer Assoc of Neuromuscular & Electrodiagnostic Med (AANEM) - 1
Pennsylvania - 18
Former President (Gurman) - 1
Delegates - 14
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
American College of Medical Genetics and Genomics (ACMGG) - 1

HAND SURGEONS - 2
American Association for Hand Surgery (AAHS) - 1
American Society for Surgery of the Hand (ASSH) - 1

HEART OF AMERICA - 8
Kansas - 3
Missouri - 5

HEMATOLOGY - 3
American Society of Hematology (ASH) - 3
Delegates - 2
Resident and Fellow Section Delegate – 1

HOSPITAL MEDICINE - 2
Society of Hospital Medicine (SHM) - 2

INFECTIOUS DISEASE - 3
Infectious Diseases Society of America (IDSA) - 3
Delegates - 2
Resident and Fellow Section Delegate - 1

INTERNAL MEDICINE - 24
American College of Physicians (ACP) – 24
Trustee (Fryhofer) – 1
Delegates - 23

NEUROSCIENCES - 25
American Academy of Child and Adolescent Psychiatry (AACAP) - 2
American Academy of Hospice and Palliative Medicine (AAHPM) - 1
American Academy of Neurology (AAN) - 3
American Academy of Pain Medicine (AAPM) - 1
American Acad of Psychiatry and the Law (AAPL) - 1
American Assoc for Geriatric Psychiatry (AAGP) - 1
American Association of Neurological Surgeons (AANS) - 2
Former President (Carmel) - 1
Delegates - 1
American Psychiatric Association (APA) - 9
Delegates - 8
Resident and Fellow Section Delegate – 1
American Society of Neuroimaging (ASNI) - 1
Congress of Neurological Surgeons (CNS) - 1
GLMA – 1
North American Neuromodulation Society (NANS) - 1
Spine Intervention Society (SIS) - 1

NEW ENGLAND - 30
Connecticut - 5
Delegates - 4
Medical Student Regional Delegate- 1
Maine - 3
Former President (McAfee) - 1
Delegates - 2
Massachusetts - 17
Trustee (Motta) -1
Delegates - 13
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
American Soc of Abdominal Surgeons (ASAS) - 1
New Hampshire - 2
Trustee (Tuttle) - 1
Delegates - 1
Rhode Island - 2
Vermont - 1

NORTH CENTRAL - 25
Iowa - 4
Delegates - 3
International Academy of Independent Medical Evaluators (IAIME) - 1
Minnesota – 6
Delegates - 5
AMDA-The Soc. for Post-Acute & Long-Term Care Medicine (AMDA) -1
Nebraska - 3
Delegates - 2
Medical Student Regional Delegate- 1
North Dakota - 1
South Dakota - 2
Delegates - 1
Medical Student Regional Delegate- 1
Wisconsin - 9
Former Board Chair (Flaherty) - 1
Delegates - 5
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
Undersea & Hyperbaric Medical Society (UHMS) - 1

OBSTETRICIANS AND GYNECOLOGISTS - 15
American College of Obstetricians and Gynecologists (ACOG) - 13
Delegates - 12
Resident and Fellow Section Delegate - 1
American Association of Gynecologic Laparoscopists (AAGL) - 2

ONCOLOGY - 3
American Society of Clinical Oncology (ASCO) - 3

ORTHOPAEDIC SURGEONS - 7
American Acad of Orthopaedic Surgeons (AAOS) - 7

PACWEST CONFERENCE - 72
Alaska - 1
Arizona - 9
Delegates - 5
Medical Student Regional Delegate- 1
American Institute of Ultrasound in Medicine (AIUM) - 2
American Orthopaedic Association (AOra) - 1
California - 32
Trustee (Ribeira) - 1
Former Presidents (Bristow, Corlin, Plested) - 3
Delegates - 22
Medical Student Regional Delegates - 1
Resident and Fellow Section Delegate - 1
American Clinical Neurophysiology Soc (ACNS) - 1
American Soc for Radiation Oncology (ASRO) - 1
American Society of Interventional Pain Physicians (ASIPP) - 2
Delegates - 1
Resident and Fellow Section Delegate - 1
Colorado - 9
Former President (Lazarus) - 1
Delegates - 5
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
Obesity Medicine Association (OMA) - 1
Hawaii - 2
Idaho - 1
Montana - 1
Nevada - 2
New Mexico - 3
Delegates - 2
American Academy of Allergy, Asthma & Immunology (AAAAI) – 1
Oregon - 3
Former President (Reardon) - 1
Delegates - 2
Utah - 4
Former Presidents (A. Nelson, J. Nelson) - 2
Delegates - 2
Washington - 4
Wyoming – 1

PATHOLOGY - 9
American Society for Clinical Pathology (ASCP) - 3
College of American Pathologists (CAP) - 3
National Association of Medical Examiners (NAME) - 1
United States and Canadian Academy of Pathology (USCAP) – 2

PEDIATRICS - 10
American Academy of Pediatrics (AAP) - 10
Delegates - 9
Resident and Fellow Section Delegate - 1

PHYSICAL MEDICINE AND REHABILITATION - 2
American Academy of Physical Med & Rehabilitation (AAPMR) - 2

PREVENTIVE MEDICINE - 6
Aerospace Medical Association (AsMA) - 1
American Academy of Insurance Medicine (AAIM) - 1
American Association of Public Health Physicians (AAPHP) - 1
American College of Medical Quality (ACMQ) - 1
American College of Occupational & Environmental Med (ACOEM) - 1
American College of Preventive Medicine (ACPM) - 1

RADIOLOGY - 9
American College of Radiology (ACR) - 7
Association of University Radiologists (AUR) - 2
Delegate - 1
Resident and Fellow Section Delegate - 1

RSNA - 4
Radiological Society of North America (RSNA) – 4
Delegates - 3
Resident and Fellow Section Delegate - 1

RHEUMATOLOGY - 2
American College of Rheumatology (ACRh) - 2

SECTIONS - 11
Academic Physicians Section (APS) - 1
Integrated Physician Practice Section (IPPS) - 1
International Medical Graduates Section (IMG) - 1
Medical Student Section (MSS) - 2
Trustee (Sarma) - 1
Delegates - 1
Minority Affairs Section (MAS) - 1
Organized Medical Staff Section (OMSS) - 1
Resident and Fellow Section (RFS) - 1
Senior Physicians Section (SPS) - 1
Women Physicians Section (WPS) -1
Young Physicians Section (YPS) - 1

SERVICES - 6
Air Force - 1
Army - 1
AMSUS - Society of Federal Health Professionals - 1
Navy - 1
Public Health Service - 1
Veterans Affairs - 1

SOUTHEASTERN - 120
Alabama - 6
Delegates - 4
Medical Student Regional Delegate- 1
American Geriatrics Society (AGS) - 1
Arkansas - 4
Trustee (Ferguson) – 1
Delegates - 3
Delaware - 3
Former Board Chair (Permut) – 1
Delegates - 1
Resident and Fellow Section Delegate - 1
District of Columbia - 3
Former Board Chair (Scalettar) - 1
Delegates - 2
Florida - 19
Former Presidents (Coble, Wilson) - 2
Delegates - 14
Medical Student Regional Delegate- 1
American College of Phlebology (ACPh) - 1
The Triological Society (TS) - 1
Georgia - 5
Kentucky - 4
Former President (Hoven) - 1
Delegates (minus Vice Speaker) - 4
Louisiana - 7
Former Presidents (Johnson, Palmisano) - 2
Delegates - 4
Medical Student Regional Delegate- 1
Maryland - 10
Trustee (Edwards) - 1
Former Board Chair (Lewers) - 1
Delegates - 5
Medical Student Regional Delegate- 1
Acad of Physicians in Clinical Research (APCR) - 1
Renal Physicians Association (RPA) - 1
Mississippi - 6
Former President (Hill) - 1
Delegates - 3
Medical Student Regional Delegate- 1
American Osteopathic Association (AOA) - 1
New Jersey - 9
Delegates - 7
Medical Student Regional Delegate- 2
North Carolina - 9
Trustee (Osbahr) - 1
Delegates - 6
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
Oklahoma - 6
Delegates - 4
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
Puerto Rico - 2
South Carolina – 8
Trustee (Harmon) - 1
Former President (Smoak) - 1
Delegates - 5
Medical Student Regional Delegate- 1
Tennessee - 8
Trustee (Williams) - 1
Delegates - 5
American Association of Physicians of Indian Origin (AAPIO) - 1
International Society for the Advancement of Spine Surgery (ISASS) - 1

SOUTHEASTERN (CONT’D.)
Virginia - 9
Former President (Wootton) - 1
Delegates - 7
Medical Student Regional Delegate- 1
West Virginia – 2

SURGEONS - 48
American Academy of Cosmetic Surgery (AACS) - 1
American Academy of Ophthalmology (AAO) - 5
Delegates - 4
Resident and Fellow Section Delegate - 1
American Academy of Otolaryngic Allergy (AAOA) - 1
Amer Acad of Otolaryngology - Head & Neck Surgery (AAOHNS) - 3
American Association for Thoracic Surgery (AATS) - 1
American Association of Plastic Surgeons (AAPS) - 1
American College of Surgeons (ACS) – 13
American Orthopaedic Foot and Ankle Society (AOFAS) - 1
American Society for Aesthetic Plastic Surgery (ASAPS) - 1
American Society for Reconstructive Microsurgery (ASRMS) - 1
American Society of Breast Surgeons (ASBS) - 1
American Society of Cataract and Refractive Surgery (ASCTRS) - 2
American Society of Colon and Rectal Surgeons (ASCRS) - 1
American Society of General Surgeons (ASGS) - 1
American Soc of Maxillofacial Surgeons (ASMS) - 1
Amer Soc of Ophthalmic Plastic & Reconstructive Surg (ASOPRS) - 1
American Society of Plastic Surgeons (ASPS) - 3
Delegates - 2
Resident and Fellow Section Delegate - 1
American Society of Retina Specialists (ASRS) - 1
American Society of Transplant Surgeons (ASTS) - 1
Contact Lens Assoc of Ophthalmologists (CLAO) - 1
International Coll of Surgeons-US Section (ICS-US) - 1
North American Spine Society (NASS) - 2
Society for Vascular Surgery (SVS) - 1
Society of Amer Gastrointestinal Endoscopic Surgeons (SAGES) - 1
Society of Laparoendoscopic Surgeons (SLR) - 1
Society of Thoracic Surgeons (STS) - 1

TERRITORIES - 2
Guam - 1
Virgin Islands - 1

TEXAS - 24
Former Presidents (Dickey, Rohack) - 2
Delegates (minus Speaker) - 18
Medical Student Regional Delegate - 1
American Association of Clinical Endocrinologists (AACE) - 1
American College of Allergy, Asthma and Immunology (ACAAI) - 1
International Society of Hair Restoration Surgery (ISHRS) – 1
National Medical Association (NMA) - 1

THORACIC MEDICINE - 2
American Thoracic Society (ATS) - 2

UROLOGY - 4
American Assoc of Clinical Urologists (AACU) - 1
American Urological Association (AUA) - 3
Delegates -2
Resident and Fellow Section Delegate - 1

OFFICIAL OBSERVERS - 28
Accreditation Association for Ambulatory Health Care
Alliance for Continuing Education in the Health Professions
Alliance for Regenerative Medicine
Ambulatory Surgery Center Association
American Academy of Physician Assistants
American Association of Medical Assistants
American Board of Medical Specialties
American Dental Association
American Health Quality Association
American Hospital Association
American Nurses Association
American Podiatric Medical Association
American Public Health Association
Association of periOperative Registered Nurses
Association of State and Territorial Health Officials
Commission on Graduates of Foreign Nursing Schools
Council of Medical Specialty Societies
Educational Commission for Foreign Medical Graduates
Federation of State Medical Boards
Federation of State Physician Health Programs
Medical Group Management Association
National Association of County and City Health Officials
National Commission on Correctional Health Care
National Council of State Boards of Nursing
National Indian Health Board
PIAA
Society for Academic Continuing Medical Education
US Pharmacopeia

TELLERS - 8

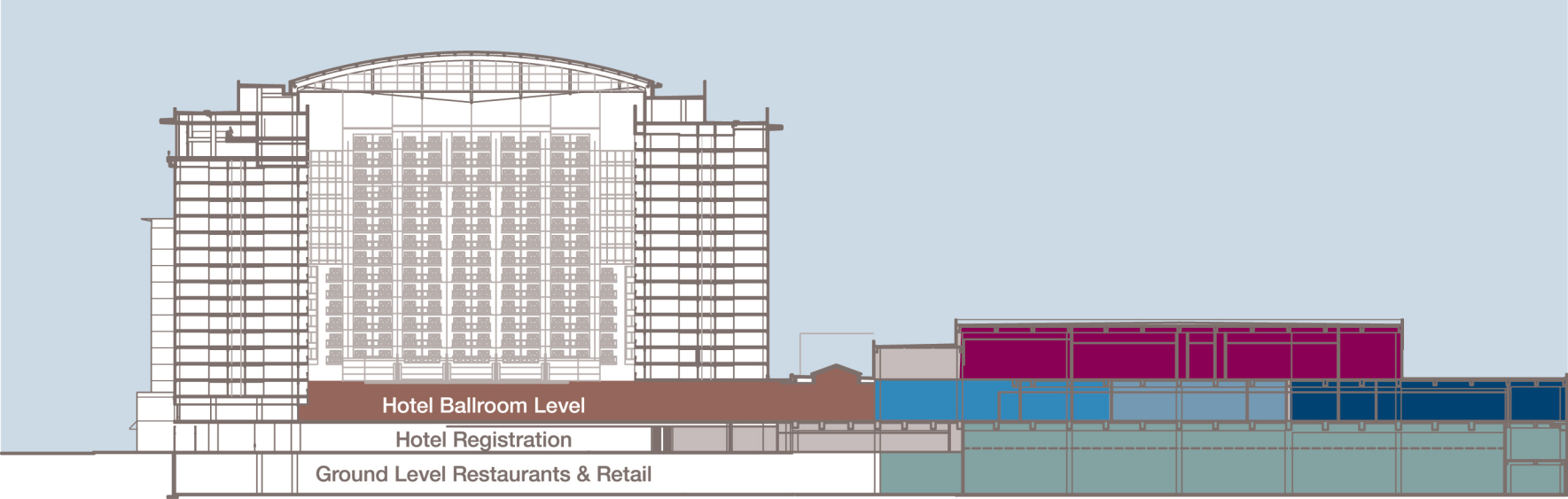
HOUSE OF DELEGATES - GAYLORD NATIONAL RESORT & CONVENTION CENTER, NATIONAL HARBOR, MARYLAND (I-18)

Audience Left

STAGE

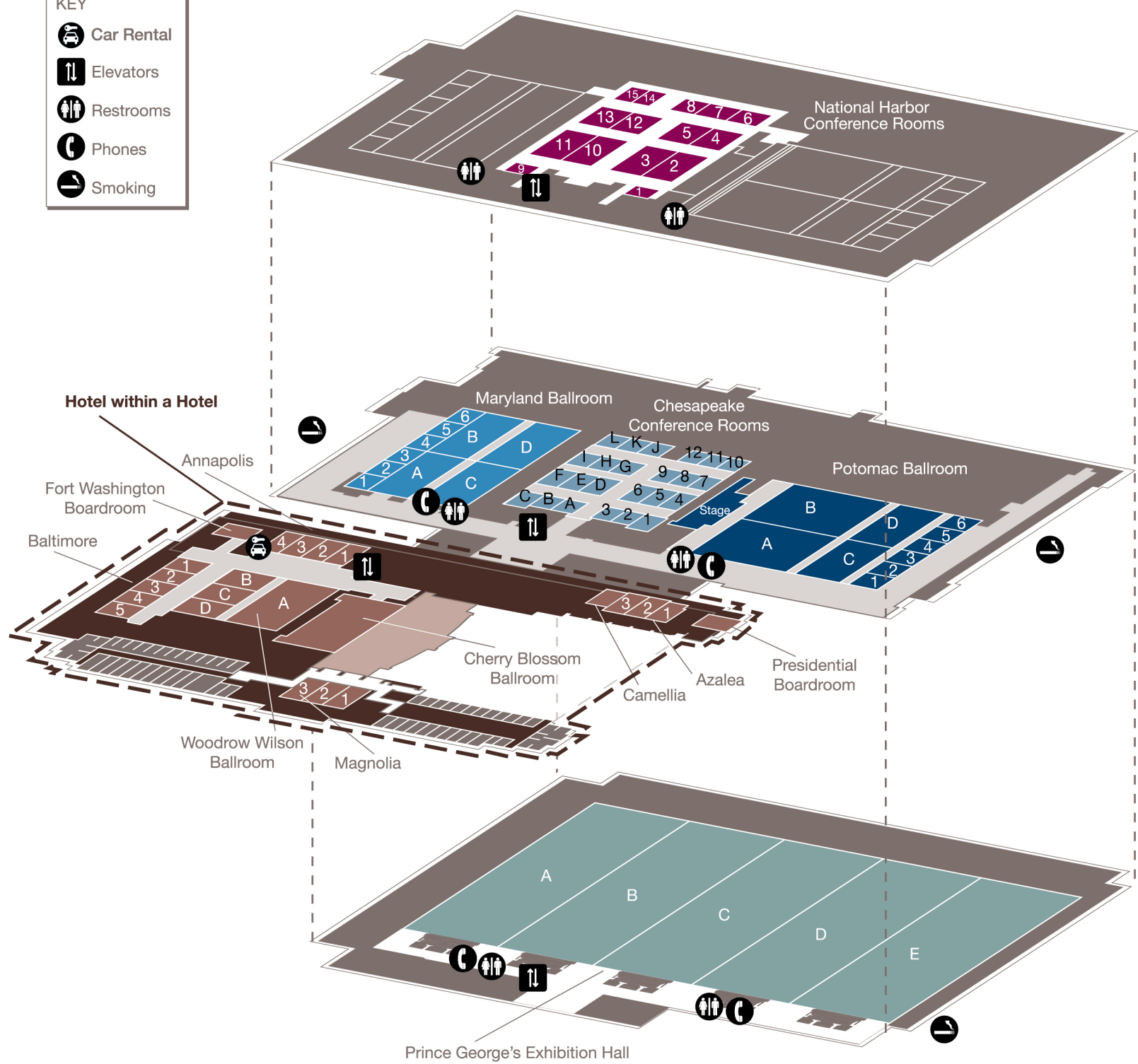
Audience Right

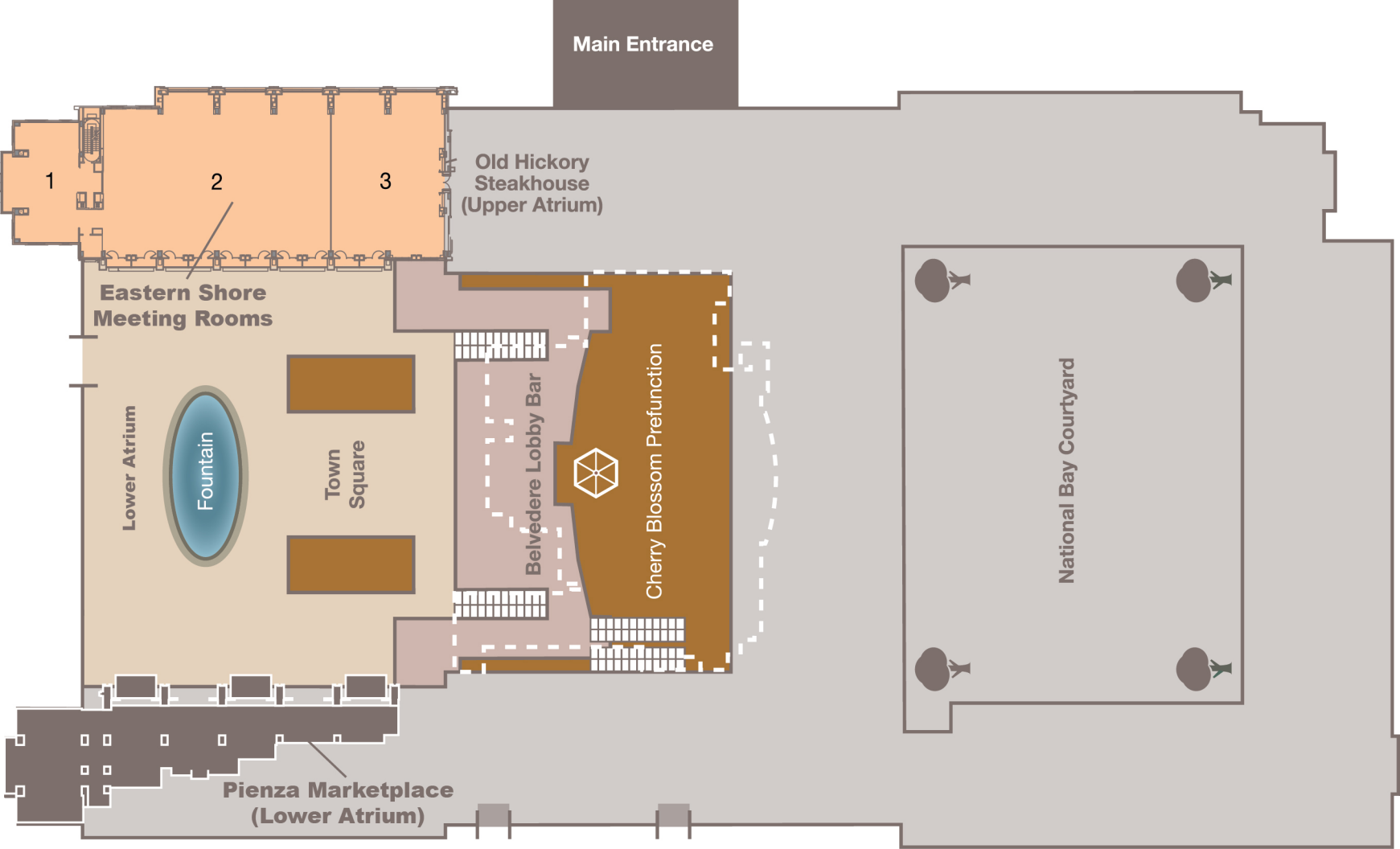
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KEY

- Car Rental
- Elevators
- Restrooms
- Phones
- Smoking





Fort Washington Boardroom

Business Center

To Convention Center
Ballroom Level

Annapolis

Camellia

Azalea

Presidential
Boardroom

Baltimore

Woodrow Wilson

Cherry Blossom
Ballroom

Ballroom
Lobby

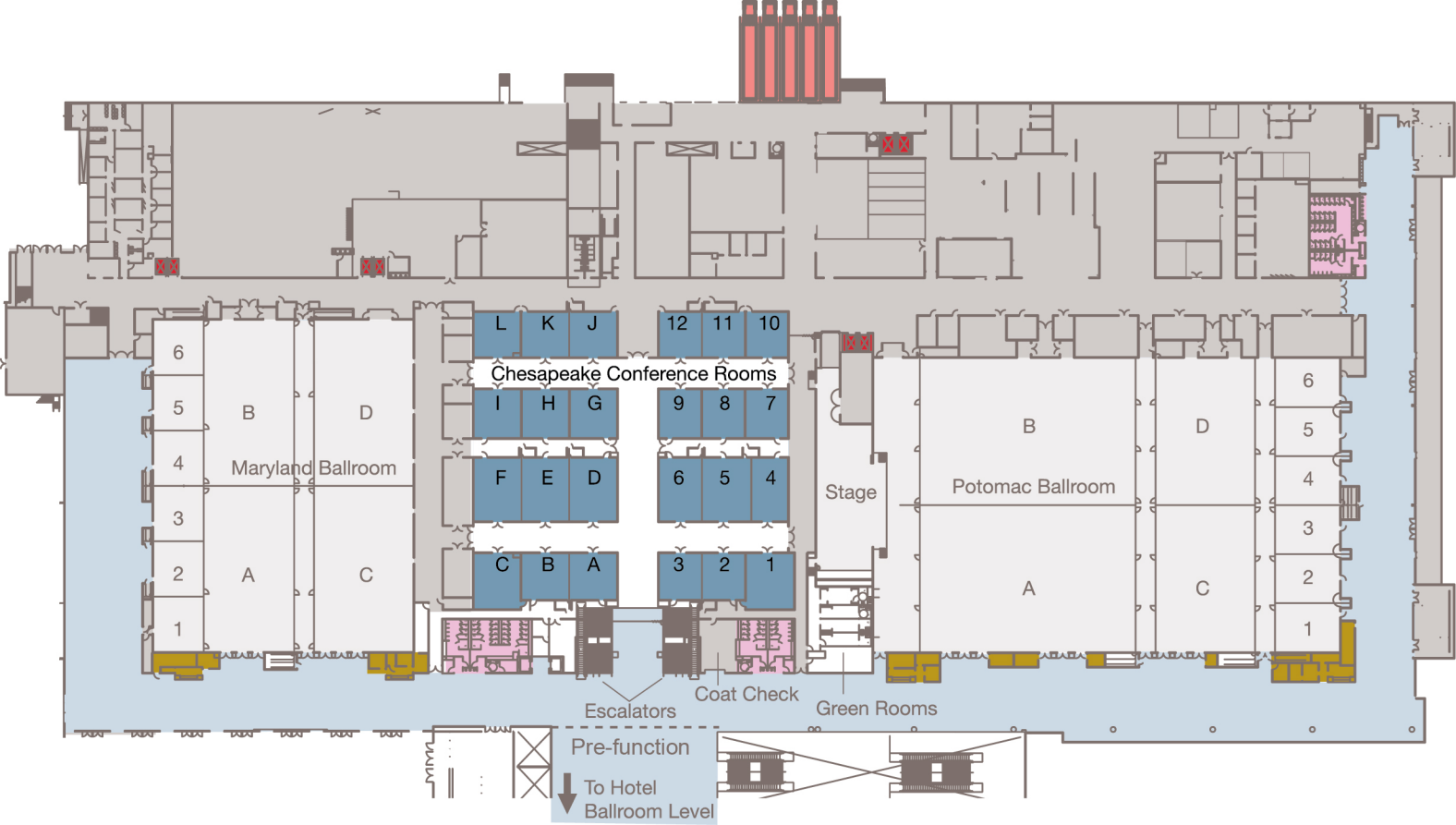
(Lower Atrium)

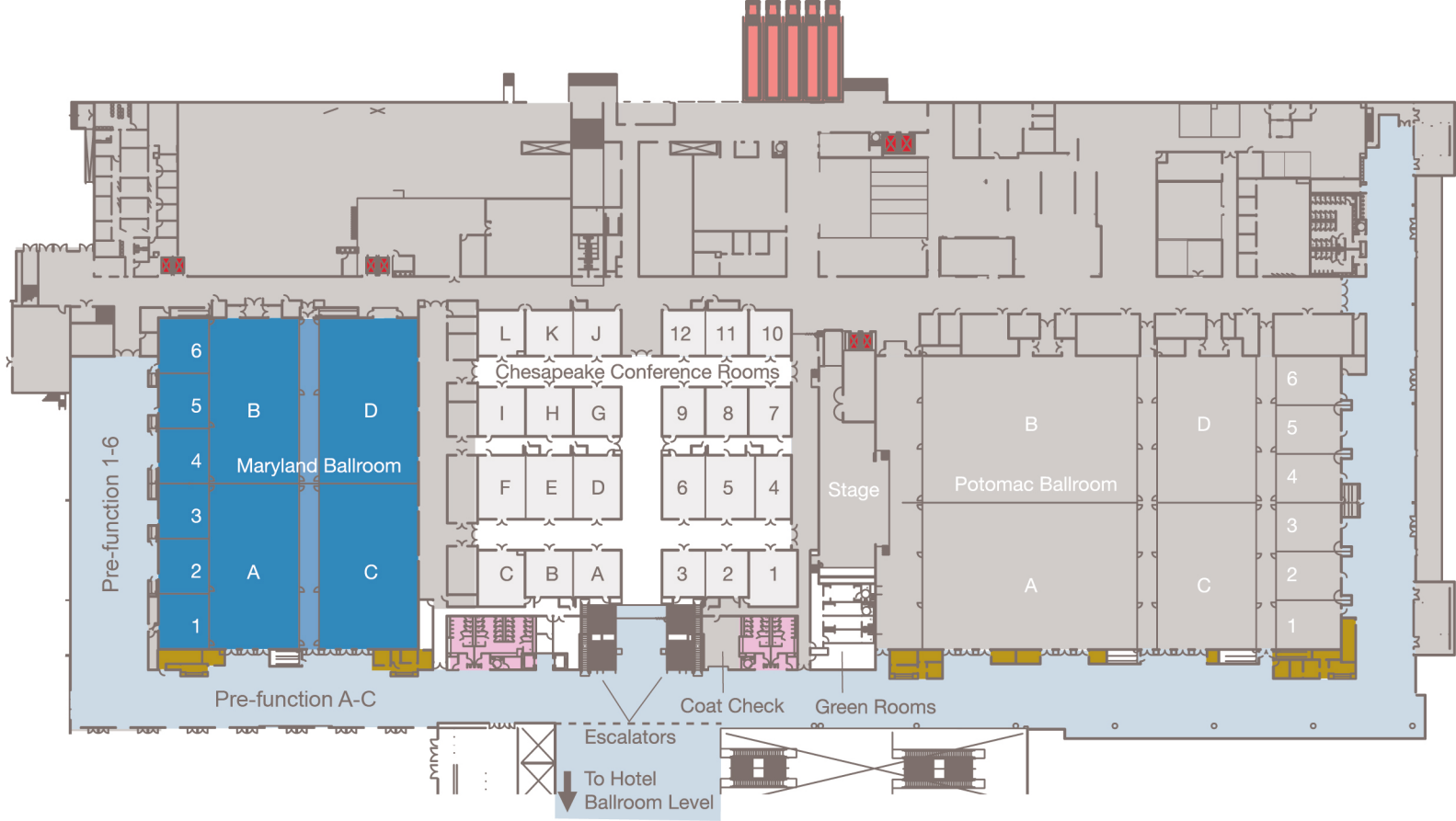
Eastern Shore
Meeting Rooms

Magnolia









2018 INTERIM MEETING

REFERENCE COMMITTEE HEARING LOCATIONS

SUNDAY, NOVEMBER 11

8:30 am-Noon

Reference Committee on Amendments to Constitution & Bylaws	Potomac A
Reference Committee B (legislation)	Potomac B
Reference Committee C (medical education)	National Harbor 10-11
Reference Committee F (AMA governance and finance)	Maryland Ballroom
Reference Committee J (medical service, medical practice, insurance)	Potomac C
Reference Committee K (science and public health)	Potomac D

2018 INTERIM MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Official Call to the Officers and Members of the American Medical Association to attend the Interim Meeting of the House of Delegates in National Harbor, Maryland, November 10-13, 2018.

The House of Delegates will convene at 2 p.m. on November 10, at the Gaylord National Resort & Convention Center, National Harbor, Maryland.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

Alabama 4	Guam 1	Massachusetts 13	New York 19	Tennessee 5
Alaska 1	Hawaii 2	Michigan 12	North Carolina 6	Texas 18
Arizona 5	Idaho 1	Minnesota 5	North Dakota 1	Utah 2
Arkansas 3	Illinois 11	Mississippi 3	Ohio 11	Vermont 1
California 22	Indiana 5	Missouri 5	Oklahoma 4	Virgin Islands 1
Colorado 5	Iowa 3	Montana 1	Oregon 2	Virginia 7
Connecticut 4	Kansas 3	Nebraska 2	Pennsylvania 14	Washington 4
Delaware 1	Kentucky 4	Nevada 2	Puerto Rico 2	West Virginia 2
District of Columbia 2	Louisiana 4	New Hampshire 1	Rhode Island 2	Wisconsin 5
Florida 14	Maine 2	New Jersey 7	South Carolina 5	Wyoming 1
Georgia 5	Maryland 5	New Mexico 2	South Dakota 1	

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

American Academy of Child and Adolescent Psychiatry 2	American Medical Group Association 3
American Academy of Dermatology 3	American Psychiatric Association 8
American Academy of Family Physicians 18	American Roentgen Ray Society 3
American Academy of Neurology 3	American Society for Clinical Pathology 3
American Academy of Ophthalmology 4	American Society for Dermatologic Surgery 2
American Academy of Orthopaedic Surgeons 7	American Society for Gastrointestinal Endoscopy 2
American Academy of Otolaryngology - Head and Neck Surgery 3	American Society of Anesthesiologists 6
American Academy of Pediatrics 9	American Society of Cataract and Refractive Surgery 2
American Academy of Physical Med. & Rehabilitation 2	American Society of Clinical Oncology 3
American Association of Gynecologic Laparoscopists 2	American Society of Echocardiography 2
American College of Cardiology 6	American Society of Hematology 2
American College of Chest Physicians 3	American Society of Plastic Surgeons 2
American College of Emergency Physicians 7	American Thoracic Society 2
American College of Gastroenterology 2	American Urological Association 2
American College of Physicians 23	College of American Pathologists 3
American College of Radiology 7	Infectious Diseases Society of America 2
American College of Rheumatology 2	North American Spine Society 2
American College of Surgeons 13	Radiological Society of North America 3
American Congress of Obstetricians and Gynecologists 12	Society of Critical Care Medicine 2
American Gastroenterological Association 2	Society of Hospital Medicine 2
American Institute of Ultrasound in Medicine 2	The Endocrine Society 2
	United States and Canadian Academy of Pathology 2

Remaining eligible national medical specialty societies (79) are entitled to one delegate each.

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

State Medical Associations	273
National Medical Specialty Societies	271
Professional Interest Medical Associations	2
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	27
Resident and Fellow Delegate Representatives	26
Sections	10
Services	5
Total Delegates	617

Registration facilities will be maintained in the Gaylord National Resort & Convention Center Foyer.

Barbara L. McAneny, MD
President

Susan R. Bailey, MD
Speaker, House of Delegates

Russell W.H. Kridel, MD
Secretary

2018-2019

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

President - Barbara L. McAneny Albuquerque, New Mexico
President-Elect - Patrice A. Harris Atlanta, Georgia
Immediate Past President - David O. Barbe..... Mountain Grove, Missouri
Secretary - Russell W.H. Kridel..... Houston, Texas
Speaker, House of Delegates - Susan R. Bailey..... Fort Worth, Texas
Vice Speaker, House of Delegates - Bruce A. Scott Louisville, Kentucky

Willarda V. Edwards (2020) Baltimore, Maryland
Jesse M. Ehrenfeld, *Chair-Elect* (2022)..... Nashville, Tennessee
E. Scott Ferguson (2022) West Memphis, Arkansas
Sandra A. Fryhofer (2022) Atlanta, Georgia
Gerald E. Harmon (2021)..... Pawleys Island, South Carolina
William E. Kobler (2020) Rockford, Illinois
William A. McDade (2020) Metairie, Louisiana
Mario E. Motta (2022) Salem, Massachusetts
S. Bobby Mukkamala (2021) Flint, Michigan
Albert J. Osbahr, III (2019)..... Hickory, North Carolina
Jack Resneck, Jr., *Chair* (2022) San Rafael, California
Ryan J. Ribeira (2019) Mountain View, California
Karthik V. Sarma (2019)..... Los Angeles, California
Georgia A. Tuttle (2019)..... Lebanon, New Hampshire
Kevin W. Williams (2020)..... Nashville, Tennessee

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS

Jerome C. Cohen, Chair, Loch Sheldrake, New York (2021); Patricia L. Austin, Vice Chair, Alamo, California (2022); Ariel Anderson, San Diego, California (Resident) (2021); Madelyn E. Butler, Tampa, Florida (2022); Pino D. Colone, Howell, Michigan (2020); Kieran McAvoy, Brookfield, Wisconsin (Student) (2019); Kevin C. Reilly, Sr., Elizabethtown, Kentucky (2022); Colette R. Willins, Westlake, Ohio (2019).
Ex Officio, without vote: Susan R. Bailey, Fort Worth, Texas; Bruce A. Scott, Louisville, Kentucky.
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

James E. Sabin, Boston, Massachusetts, Chair (2019); Kathryn L. Moseley, Ann Arbor, Michigan, Vice-Chair (2020); Kimberly A. Chernoby, Indianapolis, Indiana (Resident) (2021); David Fleming, Columbia, Missouri (2024); Jeremy A. Lazarus, Greenwood Village, Colorado (2025); Alexander M. Rosenau, Allentown, Pennsylvania (2022); Lauren Schleimer, Cambridge, Massachusetts (Student) (2019); Peter A. Schwartz, Reading, Pennsylvania (2023); Monique A. Spillman, Dallas, Texas (2021).
Secretary: Elliott Crigger, Chicago, Illinois.

COUNCIL ON LEGISLATION

Willie Underwood, III, Buffalo, New York, Chair (2019); David T. Tayloe, Jr., Goldsboro, North Carolina, Vice Chair (2019); David H. Aizuss, Encino, California (2019); Vijaya L. Appareddy, Chattanooga, Tennessee (2019); Hans C. Arora, Cleveland Heights, Ohio (Resident) (2019); Mary S. Carpenter, Winner, South Dakota (2019); Gary W. Floyd, Keller, Texas (2019); Linda B. Ford, Bellevue, Nebraska (AMPAC Observer) (2019); Marilyn J. Heine, Dresher, Pennsylvania (2019); Beth Irish, Bend, Oregon (Alliance Liaison) (2019); Tripti C. Kataria, Chicago, Illinois (2019); Ajeet Singh, Boston, Massachusetts (Student) (2019); Heather A. Smith, New York, New York (2019); Marta J. Van Beek, Iowa City, Iowa (2019).
Secretary: George Cox, Washington, District of Columbia.

COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

Alfred Herzog, Hartford, Connecticut, Chair (2019); James Goodyear, North Wales, Pennsylvania, Vice Chair (2021); Michelle Berger, Austin, Texas (2022); Edmond Cabbabe, St. Louis, Missouri (2021); Clarence Chou, Milwaukee, Wisconsin (2020); J. Steven Ekman, St. Louis, Missouri (Student) (2019); Matthew Lecuyer, Providence, Rhode Island (Resident) (2019); Glenn A. Loomis, LaGrangeville, New York (2019); Shannon Pryor, Washington, District of Columbia (2020); Gary Thal, Northbrook, Illinois (2021).

Secretary: Susan Close, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION

Carol D. Berkowitz, Torrance, California, Chair (2019); Jacqueline A. Bello, Bronx, New York, Chair-Elect (2021); Lynne M. Kirk, Dallas, Texas (2019); Rohit Abraham, East Lansing, Michigan (Student) (2019); Robert B. Goldberg, New York, New York (2021); Cynthia A. Jumper, Lubbock, Texas (2020); Liana Puscas, Durham, North Carolina (2021); Niranjan V. Rao, New Brunswick, New Jersey (2022); Luke V. Selby, Denver, Colorado (Resident) (2020); Krystal L. Tomei, Cleveland, Ohio (2021); Patricia L. Turner, Chicago, Illinois (2019); John P. Williams, Pittsburgh, Pennsylvania (2019).

Secretary: Carrie Radabaugh, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE

James G. Hinsdale, San Jose, California, Chair (2019); W. Alan Harmon, Jacksonville, Florida, Chair-Elect (2020); Betty Chu, Bloomfield Hills, Michigan (2022); Meena Davuluri, New York, New York (Resident) (2020); Lisa Egbert, Dayton, Ohio (2021); Stephen Epstein, Boston, Massachusetts (2022); Lynn Jeffers, Camarillo, California (2020); Asa Lockhart, Tyler, Texas (2022); Thomas Madejski, Medina, New York (2019); Sheila Rege, Pasco, Washington (2022); Sarah Smith, Anaheim, California (Student) (2019); Lynda M. Young, Worcester, Massachusetts (2021).

Secretary: Val Carpenter, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH

Robyn F. Chatman, Cincinnati, Ohio, Chair (2019); Michael M. Miller, Madison, Wisconsin, Chair-Elect (2022); John T. Carlo, Dallas, Texas (2021); Noel N. Deep, Antigo, Wisconsin (2019); Alexander Ding, Belmont, California (2020); Rachel Ekaireb, San Francisco, California (Student) (2019); Kira A. Geraci-Ciardullo, Mamaroneck, New York (2022); Mary LaPlante, Cleveland, Ohio (2021); Michael Lubrano, San Francisco, California (Resident) (2020); Padmini Ranasinghe, Baltimore, Maryland (2022); Bruce M. Smoller, Chevy Chase, Maryland (2019); David J. Welsh, Batesville, Indiana (2020).

Secretary: Andrea Garcia, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE

Vidya S. Kora, Michigan City, Indiana, Chair; Lyle S. Thorstenson, Nacogdoches, Texas, Secretary; Grayson W. Armstrong, Boston, Massachusetts (Resident); Brooke M. Buckley, Annapolis, Maryland; Steven J. Fleischman, New Haven, Connecticut; Linda B. Ford, Bellevue, Nebraska; Benjamin Z. Galper, McLean, Virginia; Dev A. GnanaDev, Colton, California; Stephen A. Imbeau, Florence, South Carolina; Ashtin Jeney, Redlands, California (Student); James L. Milam, Libertyville, Illinois; Michael Suk, Danville, Pennsylvania.

Executive Director and Treasurer: Kevin Walker, Washington, District of Columbia.

MEMBERS OF THE HOUSE OF DELEGATES - NOVEMBER 2018
The following is a list of delegates and alternate delegates to the House of Delegates
as reported to the Executive Vice President

Medical Association of the State of Alabama

Delegate(s)

Jorge Alsip, Daphne AL
Steven P. Furr, Jackson AL
B Jerry Harrison, Haleyville AL
George C. Smith, Lineville AL

Alternate Delegate(s)

Raymond Broughton, Theodore AL
Harry Kuberg, Russellville AL
John Meigs, Brent AL
William Schneider, Huntsville AL

Regional Medical Student Delegate(s)

Hannah M Ficarino, Mobile AL

Alaska State Medical Association

Delegate(s)

Alex Malter, Juneau AK

Alternate Delegate(s)

Mary Ann Foland, Anchorage AK

Arizona Medical Association

Delegate(s)

Daniel P. Aspery, Phoenix AZ
Veronica K. Dowling, Show Low AZ
Gary R. Figge, Tucson AZ
Thomas H. Hicks, Tucson AZ
M Zuhdi Jasser, Phoenix AZ

Alternate Delegate(s)

Timothy Fagan, Tucson AZ
Ross F. Goldberg, Phoenix AZ
Michael Hamant, Tucson AZ
Marc Leib, Phoenix AZ
Elise Molnar, Phoenix AZ

Regional Medical Student Delegate(s)

Adam Roussas, Tucson AZ

Regional Medical Student Alternate Delegate(s)

Sanjay Menghani, Vineland NJ

Arkansas Medical Society

Delegate(s)

Omar Atiq, Little Rock AR

Arkansas Medical Society

Delegate(s)

G. Edward Bryant, West Memphis AR
Alan Wilson, Crossett AR

Alternate Delegate(s)

Amy Cahill, Pine Bluff AR
Eugene Shelby, Hot Springs AR

California Medical Association

Delegate(s)

David H. Aizuss, Encino CA
Mark Ard, Redlands CA
Barbara J. Arnold, Sacramento CA
Patricia L. Austin, Alamo CA
Edward Bentley, Santa Barbara CA
Peter N. Bretan, Watsonville CA
J Brennan Cassidy, Newport Beach CA
Luther Cobb, Eureka CA
Kyle P. Edmonds, San Diego CA
James T. Hay, Del Mar CA
Robert Hertzka, Rancho Santa Fe CA
James G. Hinsdale, San Jose CA
Vito Imbasciani, Los Angeles CA
Steven E. Larson, Riverside CA
Arthur N. Lurvey, Los Angeles CA
Ramin Manshadi, Stockton CA
Robert J. Margolin, San Francisco CA
Theodore Mazer, San Diego CA
Albert Ray, San Diego CA
Sarah M. Smith, Anaheim CA
Tatiana W. Spirtos, Redwood City CA
James J. Strebig, Irvine CA

Alternate Delegate(s)

Dirk Stephen Baumann, Burlingame CA
Jeffrey Brackett, Ventura CA
Lawrence Cheung, San Francisco CA
James Cotter, Fairfield CA
Melanie Crane, Riverside CA
Alexander Ding, Belmont CA
Suparna Dutta, Oakland CA
Gordon Fung, San Francisco CA
Dev A. GnanaDev, Redlands CA

This list does not reflect temporary changes for this meeting.

California Medical Association

Alternate Delegate(s)

Samuel Huang, Los Angeles CA
Scott Richard Karlan, West Hollywood CA
Nikan Khatibi, Laguna Niguel CA
Mark H. Kogan, San Pablo CA
Sandra Mendez, Sacramento CA
Chang Na, Bakersfield CA
Abhinaya Narayanan, Los Angeles CA
Richard Pan, Sacramento CA
Mihir Parikh, La Jolla CA
Timothy Parker, Jr., San Diego CA
Sion Roy, Torrance CA
Holly Yang, San Diego CA
Marcy Zwelling-Aamot, Los Alamitos CA

Resident and Fellow Sectional Delegate(s)

Hunter Pattison, Sacramento CA

Resident and Fellow Sectional Alternate Delegate(s)

Jacob Burns, Sacramento CA

Regional Medical Student Delegate(s)

Rachel Ekaireb, San Francisco CA

Regional Medical Student Alternate Delegate(s)

Cecilia Leggett, San Diego CA
Neil Rens, Stanford CA

Colorado Medical Society

Delegate(s)

David Downs, Denver CO
Jan Kief, Highlands Ranch CO
A. "Lee" Morgan, Denver CO
Tamaan Osbourne-Roberts, Denver CO
Lynn Parry, Littleton CO

Alternate Delegate(s)

Carolynn Francavilla, Lakewood CO
Rachelle M. Klammer, Denver CO
Katie Lozano, Centennial CO
Brigitta J. Robinson, Centennial CO
Michael Volz, Englewood CO

Resident and Fellow Sectional Delegate(s)

Luke V. Selby, Denver CO

Regional Medical Student Delegate(s)

Adam Panzer, Staten Island NY

Colorado Medical Society

Regional Medical Student Alternate Delegate(s)

Halea K Meese, Denver CO

Connecticut State Medical Society

Delegate(s)

Michael L. Carius, Stratford CT
Michael M. Deren, New London CT
Alfred Herzog, Hartford CT
Theodore Zanker, Cheshire CT

Alternate Delegate(s)

Claudia Gruss, Redding CT
Katherine L. Harvey, Torrington CT
Bollepalli Subbarao, Middletown CT
Steven C. Thornquist, Bethany CT

Regional Medical Student Delegate(s)

Devin Bageac, Farmington CT

Regional Medical Student Alternate Delegate(s)

Kathryn Topalis, Simsbury CT

Medical Society of Delaware

Delegate(s)

Kelly S. Eschbach, Wilmington DE

Alternate Delegate(s)

Janice Tildon-Burton, Wilmington DE

Resident and Fellow Sectional Delegate(s)

Ankit Agarwal, Chapel Hill NC

Medical Society of the District of Columbia

Delegate(s)

Joseph E. Gutierrez, McLean VA
Peter E. Lavine, Washington DC

Alternate Delegate(s)

J Desiree Pineda, Washington DC
Raymond K. Tu, Washington DC

Regional Medical Student Alternate Delegate(s)

Damani McIntosh-Clarke, Arlington VA

Florida Medical Association

Delegate(s)

Christienne P. Alexander, Tallahassee FL
David Becker, Safety Harbor FL

This list does not reflect temporary changes for this meeting.

Florida Medical Association

Delegate(s)

Madelyn E. Butler, Tampa FL
Ronald Frederic Giffler, Fort Lauderdale FL
Walter Alan. Harmon, Jacksonville FL
Corey L. Howard, Naples FL
E Coy Irvin, Pensacola FL
Trachella Johnson Foy, Jacksonville FL
John Montgomery, Fleming Island FL
Douglas Murphy, Ocala FL
Ralph Jacinto Nobo, Bartow FL
Michael L. Patete, Venice FL
Aaron Sudbury, Bradenton FL
Hansel Emory Tookes, III, Miami FL

Alternate Delegate(s)

Ankush Bansal, West Palm Beach FL
Andrew Cooke, Orlando FL
Aaron Elkin, Miami FL
James Nathan Goldenberg, Atlantis FL
Raphael C. Haciski, Naples FL
Lawrence S. Halperin MD, Winter Park FL
Rebecca Lynn Johnson, Tampa FL
Arthur E. Palamara, Hollywood FL
Mark E. Panna, Gainesville FL
Alan B. Pillersdorf, Lake Worth FL
Sergio B. Seoane, Barton FL
James St George, Ponte Verdra FL
Michael Zimmer, St Petersburg FL

Regional Medical Student Delegate(s)

Jessica Walsh O'Sullivan, Orlando FL

Regional Medical Student Alternate Delegate(s)

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Tanya Singh, Orlando FL

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Michael E. Greene, Columbus GA
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Alternate Delegate(s)

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Jack Chapman, Gainesville GA
John Goldman, Atlanta GA

Medical Association of Georgia

Alternate Delegate(s)

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Gary Richter, Atlanta GA

Resident and Fellow Sectional Alternate Delegate(s)

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Guam Medical Society

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Insaf Ally, Tamuning GU

Alternate Delegate(s)

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Hawaii Medical Association

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Roger Kimura, Honolulu HI

Alternate Delegate(s)

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Idaho Medical Association

Delegate(s)

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Alternate Delegate(s)

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Craig Alvin Backs, Springfield IL
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Howard Chodash, Springfield IL
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Richard A. Geline, Glenview IL
Steve Malkin, Arlington Heights IL
James L. Milam, Libertyville IL
Nestor Ramirez-Lopez, Champaign IL
Shastri Swaminathan, Chicago IL

Alternate Delegate(s)

Rodney Alford, Watseka IL
Howard Axe, Arlington Heights IL
Christine Bishof, Forest Park IL
Scott A. Cooper, Chicago IL

This list does not reflect temporary changes for this meeting.

Illinois State Medical Society

Alternate Delegate(s)

Farhad Ghamsari, Chicago IL
Lynne E. Nowak, Belleville IL
Robert Panton, Elmwood Park IL
Vikram B. Patel, South Barrington IL
Laura Shea, Springfield IL
Katherine Tynus, Chicago IL
Piyush Vyas, Lake Forest IL

Resident and Fellow Sectional Alternate Delegate(s)

Marla Rejbi, Chicago IL

Regional Medical Student Delegate(s)

Ajeet Singh, Forest Park IL

Regional Medical Student Alternate Delegate(s)

Ian Magruder, Wilmette IL

Indiana State Medical Association

Delegate(s)

Michael Hoover, Evansville IN
Vidya S. Kora, Michigan City IN
William Mohr, Kokomo IN
Stephen Tharp, Frankfort IN
David Welsh, Batesville IN

Alternate Delegate(s)

Deepak Azad, Floyds Knobs IN
Heidi Dunniway, Indianapolis IN
Brent Mohr, South Bend IN
Rhonda Sharp, Lagrange IN
Thomas Vidic, Elkhart IN

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Iowa Medical Society

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Robert Lee, Johnston IA
Victoria Sharp, Iowa City IA

Alternate Delegate(s)

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Iowa Medical Society

Alternate Delegate(s)

Marygrace Elson, Iowa City IA
Douglas Peters, W Burlington IA

Resident and Fellow Sectional Alternate Delegate(s)

Daniel Terveen, Iowa City IA

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Arthur D. Snow, Shawnee Mission KS
Richard B. Warner, Shawnee Mission KS

Alternate Delegate(s)

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James H. Gilbaugh, Wichita KS

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Shawn C. Jones, Paducah KY
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Myo Myint, New Orleans LA
Lee Stevens, Shreveport LA

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Rachel Spann, New Orleans LA

Regional Medical Student Delegate(s)

Neal Dixit, New Orleans LA

Maine Medical Association

Delegate(s)

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Maroulla S. Gleaton, Augusta ME

This list does not reflect temporary changes for this meeting.

Maine Medical Association

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Robert Schlager, Pittsfield ME

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Harbhajan Ajrawat, Potomac MD
Loralie Dawn Ma, Fulton MD
Shannon Pryor, Chevy Chase MD
Stephen J. Rockower, Rockville MD
Bruce M. Smoller, Potomac MD

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Brooke M. Buckley, Annapolis MD
Keshav Khanijow, Baltimore MD
Gary Pushkin, Baltimore MD
Padmini Ranasinghe, Baltimore MD

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Massachusetts Medical Society

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Spiro Spanakis, Shrewsbury MA
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Andrew Vallejo, Boston MA

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Amit Ghose, Lansing MI
Nabiha Hashmi, Troy MI
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John A. Waters, Flint MI

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Nonie Arora, Ann Arbor MI

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Minnesota Medical Association

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David D. Luehr, Barnum MN
Paul C. Matson, Mankato MN
Cindy F. Smith, Willmar MN

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Andrea Hillerud, Saint Paul MN
Kathryn Lombardo, Rochester MN
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Edmond Cabbabe, St Louis MO
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Ravi S Johar, Maryland Heights MO
Michael L. O'Dell, Kansas City MO
Shannon Tai, Lisle IL
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Alternate Delegate(s)

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Alternate Delegate(s)

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Nevada State Medical Association

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Florence Jameson, Las Vegas NV

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Peter R. Fenwick, Reno NV

Regional Medical Student Delegate(s)

Neha Agrawal, Reno NV

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Alternate Delegate(s)

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Joseph J. Fallon, Woodbury NJ
Charles Michael Moss, Ramsey NJ
John W. Poole, Ridgewood NJ
Niranjan V. Rao, Somerset NJ
David Swee, Piscataway NJ

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Donald M. Chervenak, Florham Park NJ
Christopher Gribbin, Princeton NJ

This list does not reflect temporary changes for this meeting.

Medical Society of New Jersey

Alternate Delegate(s)

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Steven P. Shikiar, Englewood NJ
Rocco Tutela, Highland Park NJ

Regional Medical Student Delegate(s)

Fatima Mirza, New Haven CT
Aakash Sheth, East Brunswick NJ

Regional Medical Student Alternate Delegate(s)

Priya Sushvet Kantesaria, Somerset NJ

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Stephen P. Lucero, Taos NM

Alternate Delegate(s)

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Sandra Lynn Whisler, Albuquerque NM

Medical Society of the State of New York

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Howard Huang, Watertown NY
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Andrew Y. Kleinman, Rye Brook NY
Daniel J. Koretz, Ontario NY
Bonnie L. Litvack, Mont Kisco NY
Thomas J. Madejski, Medina NY
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Gregory L. Pinto, Saratoga Springs NY
Malcolm D. Reid, New York NY
Charles Rothberg, Patchogue NY
Joseph Sellers, Cobleskill NY
Corliss Varnum, Oswego NY

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Rose Berkun, Buffalo NY
Breyen Coffin, Bronx NY

Medical Society of the State of New York

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Parag Mehta, New Hyde Park NY
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Barry Rabin, Syracuse NY
Abdul Rehman, Staten Island NY
Richard Vienne, Buffalo NY

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Raymond Lorenzoni, New York NY

Regional Medical Student Delegate(s)

Usman Aslam, Glen Cove NY
Ali Bokhari, Brooklyn NY

Regional Medical Student Alternate Delegate(s)

Michael Healey, Rochester NY
Rishi Thaker, Middletown NY

North Carolina Medical Society

Delegate(s)

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Mary Ann Contogiannis, Greensboro NC
John A. Fagg, Winston-Salem NC
John R. Mangum, Sanford NC
Darlyne Menscer, Charlotte NC
Charles F. Willson, Greenville NC

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Liana Puscas, Durham NC

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Jason Hall, Durham NC

Regional Medical Student Delegate(s)

Lauren Benning, Litlington NC

Regional Medical Student Alternate Delegate(s)

Lauren Edgar, Winston-Salem NC
Elyse Whithorn, Fayetteville NC

North Dakota Medical Association

Delegate(s)

Shari L. Orser, Bismarck ND

This list does not reflect temporary changes for this meeting.

North Dakota Medical Association

Alternate Delegate(s)

A. Michael Booth, Bismarck ND

Ohio State Medical Association

Delegate(s)

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Louito C. Edje, Toledo OH
Lisa B. Egbert, Kettering OH
Richard R. Ellison, Fairlawn OH
Charles J. Hickey, Dublin OH
Gary R. Katz, Dublin OH
William C. Sternfeld, Toledo OH
Carl S. Wehri, Delphos OH
Donna A. Woodson, Toledo OH

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Shawn Cuevas, Columbus OH
Deepak Kumar, Dayton OH
Julie Lin, Rootstown OH
Regina Whitfield-Kekessi, West Chester OH

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Katherine Chen, Toledo OH
Hari Iyer, Rootstown OH

Regional Medical Student Alternate Delegate(s)

Paige Anderson, Vermilion OH

Oklahoma State Medical Association

Delegate(s)

Sherri Baker, Oklahoma City OK
Jack J. Beller, Norman OK
Jay A. Gregory, Muskogee OK
Bruce Storms, Chickasha OK

Alternate Delegate(s)

Peter Aran, Tulsa OK
Jenny Boyer, Tulsa OK
Woody Jenkins, Stillwater OK
Kevin Taubman, Tulsa OK

Resident and Fellow Sectional Delegate(s)

Eudy Bosley, Broken Arrow OK

Oklahoma State Medical Association

Regional Medical Student Delegate(s)

Chelsea McKenzie, Tulsa OK

Regional Medical Student Alternate Delegate(s)

Mayra Salazar-Valdivia, Tulsa OK

Oregon Medical Association

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Sylvia Ann Emory, Eugene OR

Alternate Delegate(s)

Peter A. Bernardo, Salem OR
Mary McCarthy, Portland OR

Pennsylvania Medical Society

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Marilyn J. Heine, Dresher PA
Daniel B. Kimball, Wyomissing PA
Peter S. Lund, Fairview PA
Anthony M. Padula, Philadelphia PA
Judith R. Prybick, Allentown PA
Ralph Schmeltz, Pittsburgh PA
Scott E. Shapiro, Lower Gwynedd PA
John W. Spurlock, Coopersburg PA
Martin D. Trichtinger, Hatboro PA
John P. Williams, Gibsonia PA

Alternate Delegate(s)

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Stephen N. Clay, Philadelphia PA
Mark Friedlander, Nabeth PA
Kevin Owen Garrett, Allison Park PA
Aaron E. George, Chambersburg PA
Bruce A. MacLeod, Pittsburgh PA
Jill M. Owens, Bradford PA
Evan Pollack, Bryn Mawr PA
Rachel Thomas, Philadelphia PA
John Trickett, Jr., Scranton PA
John Michael Vasudevan, Philadelphia PA

Resident and Fellow Sectional Delegate(s)

Raghuveer Puttagunta, Danville PA

This list does not reflect temporary changes for this meeting.

Pennsylvania Medical Society

Regional Medical Student Delegate(s)

Nichole Ogojiaku, Marietta GA

Regional Medical Student Alternate Delegate(s)

Daniel Kim, Harrisburg PA

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Delegate(s)

Gonzalo V. Gonzalez-Liboy, Carolina PR
Rafael Rodriguez-Mercado, San Juan PR

Alternate Delegate(s)

Feliberti Rafael Fernandez, Guaynabo PR
Jose Luis Romany Rodriguez, San Juan PR

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Delegate(s)

Alyn L. Adrain, Providence RI
Peter A. Hollmann, Cranston RI

Alternate Delegate(s)

Sarah Fessler, Riverside RI

South Carolina Medical Association

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Gary A. Delaney, Orangeburg SC
Richard Osman, Myrtle Beach SC
H Timberlake Pearce, Beaufort SC
Bruce A. Snyder, Greenville SC
Greg Tarasidis, Greenwood SC

Alternate Delegate(s)

Stephen Imbeau, Florence SC
Stefanie M. Putnam, Mauldin SC
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John Ropp, III, Hartsville SC
Todd E Schlesinger, Charleston SC

Regional Medical Student Delegate(s)

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Delegate(s)

Mary Carpenter, Winner SD

Alternate Delegate(s)

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Donald B. Franklin, Signal Mountain TN
John J. Ingram, Alcoa TN
James D. King, Selmer TN
Wiley T. Robinson, Memphis TN

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Matthew Mancini, Knoxville TN
Nita Shumaker, Hixson TN
Richard G. Soper, Nashville TN
Christopher E. Young, Signal Mtn TN

Texas Medical Association

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Brad G. Butler, Abilene TX
Diana Fite, Magnolia TX
David C. Fleeger, Austin TX
William H. Fleming, Houston TX
Gary Floyd, Keller TX
John T. Gill, Dallas TX
Robert T. Gunby, Dallas TX
David N. Henkes, San Antonio TX
Asa C. Lockhart, Tyler TX
Kenneth L. Mattox, Houston TX
Kevin H. McKinney, Galveston TX
Larry E. Reaves, Fort Worth TX
Leslie H. Secrest, Dallas TX
Jayesh Shah, San Antonio TX
Lyle S. Thorstenson, Nacogdoches TX
E. Linda Villarreal, Edinburg TX

Alternate Delegate(s)

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John T. Carlo, Dallas TX
Robert H. Emmick, Austin TX
John G. Flores, Little Elm TX
Gregory M. Fuller, Keller TX
Laura Faye Gephart, Temple TX
William S. Gilmer, Houston TX
Steven R. Hays, Dallas TX
Cynthia Jumper, Lubbock TX
Faith Mason, Galveston TX

This list does not reflect temporary changes for this meeting.

Texas Medical Association

Alternate Delegate(s)

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Jennifer Rushton, Austin TX
Elizabeth Torres, Sugar Land TX
Roxanne Tyroch, El Pasco TX
Arlo F. Weltge, Bellaire TX
Sherif Z. Zaafran, Houston TX

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Regional Medical Student Delegate(s)

Luis Seija, Temple TX

Regional Medical Student Alternate Delegate(s)

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Robert Kotaki, McAllen TX
Aaron J Wolbrueck, Fort Worth TX

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Patrice Hirning, Salt Lake City UT

Alternate Delegate(s)

Kerry Fisher, Salt Lake City UT
Richard Labasky, Sandy UT

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Delegate(s)

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Alternate Delegate(s)

Norman Ward, Burlington VT

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Randolph J. Gould, Norfolk VA
Edward G. Koch, McLean VA
Hazle S. Konerding, Richmond VA
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Lawrence K. Monahan, Roanoke VA

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Clifford L. Deal, Henrico VA

Medical Society of Virginia

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Bhushan H. Pandya, Danville VA
Sterling N. Ransone, Deltaville VA
William Reha, Woodridge VA
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Ryan Schlobach, Norfolk VA

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Abby Winn, Roanoke VA

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L Elizabeth Peterson, Spokane WA
Sheila D. Rege, Pasco WA
Rodney Trytko, Spokane WA

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Matthew Grierson, Bothell WA
Nariman Heshmati, Muklito WA
Shane Macaulay, Kirkland WA

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Delegate(s)

Hoyt Burdick, Huntington WV
Joseph Barry Selby, Morgantown WV

Alternate Delegate(s)

James D. Felsen, Great Cacapon WV
Ron Stollings, Madison WV

Wisconsin Medical Society

Delegate(s)

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George Melvin Lange, Milwaukee WI
Michael M. Miller, Madison WI
Charles J. Rainey, River Hills WI
Paul A. Wertsch, Madison WI

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Cyril M. Hetsko, Madison WI
Don Lee, Franklin WI
Timothy G. Mc Avoy, Waukesha WI

This list does not reflect temporary changes for this meeting.

Wisconsin Medical Society

Alternate Delegate(s)

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Regional Medical Student Delegate(s)

Michael Rigby, Madison WI

Regional Medical Student Alternate Delegate(s)

Nathan J Carptenter, Milwaukee WI

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Delegate(s)

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Alternate Delegate(s)

Paul Johnson, Cheyenne WY

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Alternate Delegate(s)

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Alternate Delegate(s)

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Marta Jane Van Beek, Iowa City IA

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Alternate Delegate(s)

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Alternate Delegate(s)

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John Cullen, Valdez AK

Elana Curry, Columbus OH

Kellen Gower, St Petersburg FL

Michael Hanak, Chicago IL

Daniel Heinemann, Canton SD

Kaci Larsen, Columbia MO

Evelyn Lynnette Lewis & Clark, Newman GA

Glenn Loomis, Hopewell Junction NY

Michael L. Munger, Overland Park KS

Anita Ravi, New York NY

Stephen Richards, Spirit Lakes IA

Lawrence Rues, Leawood KS

Hugh Taylor, Hamilton MA

Janet West, Pensacola FL

Colette R. Willins, Avon OH

J. Mack Worthington, Chattanooga TN

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Samuel Mathis, Galveston TX

Julie K. Wood, Leawood KS

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Chad D. Kollas, Orlando FL

American Academy of Insurance Medicine**Delegate(s)**

Deborah Y. Smart, Gurnee IL

This list does not reflect temporary changes for this meeting.

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Ann Murray, Morgantown WV

Eugene Scharf, Rochester MN

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Lisa Nijm, Warrenville IL

Mildred M G. Olivier, Arlington Heights IL

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Michael Suk, Danville PA

Kimberly Jo Templeton, Leawood KS

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American Academy of Otolaryngic Allergy**Delegate(s)**

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American Academy of Otolaryngology-Head and Neck Surgery**Delegate(s)**

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Douglas R. Myers, Vancouver WA

American Academy of Otolaryngology-Head and Neck Surgery**Delegate(s)**

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Alternate Delegate(s)

Donna Bloodworth, Alvin TX

American Academy of Pediatrics**Delegate(s)**

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Carol Berkowitz, Rancho Palos Verdes CA

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Zarah Iqbal, Gladwyne PA

Colleen Kraft, Mission Viejo CA

Samantha Rosman, Jamaica Plain MA

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American Academy of Physical Medicine and Rehabilitation**Delegate(s)**

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Susan L. Hubbell, Lima OH

Alternate Delegate(s)

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Carlo Milani, New York NY

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Barry Wall, Providence RI

Alternate Delegate(s)

Jennifer Piel, Seattle WA

American Association for Geriatric Psychiatry**Delegate(s)**

Allan Anderson, Easton MD

This list does not reflect temporary changes for this meeting.

American Association for Hand Surgery**Delegate(s)**

Peter C. Amadio, Rochester MN

Alternate Delegate(s)

Nicholas B. Vedder, Seattle WA

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Committee on Rules and Credentials

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Beverly Collins, MD, American College of Medical Quality
Ralph J. Nobo, Jr., MD, Florida
Kevin C. Reilly, Sr., MD, Radiological Society of North America
Colette R. Willins, MD, American Academy of Family Physicians

Chief Teller

Billie L. Jackson, MD, Georgia

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

2018 Interim Meeting Notes on Orders of Business

FIRST SESSION, Saturday, November 10, 2:00 – 6:00 pm

SECOND SESSION, Sunday, November 11, 8:00 – 8:30 am

THIRD SESSION, Monday, November 12, 2:00 – 6:00 pm

FOURTH SESSION, Tuesday, November 13, 8:30 am – noon

SUMMARY OF FISCAL NOTES (I-18)

BOT Report(s)

- 01 Data Used to Apportion Delegates: n/a
- 02 Redefining AMA's Position on ACA and Healthcare Reform: Info Report
- 03 2018 AMA Advocacy Efforts: Info Report
- 04 Increased Use of Body-Worn Cameras by Law Enforcement Officers: Modest
- 05 Exclusive State Control of Methadone Clinics: Modest
- 06 Update on TruthinRx Grassroots Campaign: Info Report
- 07 Advocacy for Seamless Interface Between Physicians Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs: Minimal
- 08 340B Drug Discount Program: Modest
- 09 Hospital Closures and Physician Credentialing: Modest
- 10 Training Physicians in the Art of Public Forum: \$20,000 for professional fees for external support and capacity to develop tools and resources
- 11 Violence Prevention: Minimal
- 12 Information Regarding Animal-Derived Medications: Minimal
- 13 2019 Strategic Plan: Info Report
- 14 Protection of Physician Freedom of Speech: Minimal

CEJA Opinion(s)

- 01 Medical Tourism: Info Report
- 02 Expanded Access to Investigational Therapies: Info Report
- 03* Mergers of Secular and Religiously Affiliated Health Care Institutions - CORRECTED: Info Report

CEJA Report(s)

- 01* Competence, Self-Assessment and Self-Awareness: Minimal
- 02* Study Aid-in-Dying and End-of-Life Option / The Need to Distinguish "Physician-Assisted Suicide" and "Aid-in-Dying": None
- 03* Amendment to E-2.2.1, "Pediatric Decision Making": Minimal
- 04* CEJA Role in Implementing H-140.837, "Anti-Harassment Policy": Minimal
- 05* Physicians' Freedom of Speech: Minimal

CLRPD Report(s)

- 01 Women Physicians Section Five-Year Review: Minimal

CME Report(s)

- 01 Competency of Senior Physicians: Minimal
- 02 Review of AMA Educational Offerings: Info Report
- 03 Developing Physician-Led Public Health / Population Health Capacity in Rural Communities: Minimal
- 04 Reconciliation of AMA Policy on Primary Care Workforce: Minimal
- 05* Reconciliation of AMA Policy on Medical Student Debt: Minimal
- 06 Reconciliation of AMA Policy on Resident/Fellow Contracts and Duty Hours: Minimal
- 07 50th Anniversary of the AMA Physicians' Recognition Award and Credit System: Info Report
- 08 Study of Medical Student, Resident and Physician Suicide: Info Report

SUMMARY OF FISCAL NOTES (I-18)

CMS Report(s)

- 01 Prescription Drug Importation for Personal Use: Minimal
- 02 Air Ambulance Regulations and Payments: Minimal
- 03* Sustain Patient-Centered Medical Home Practices: Minimal
- 04 The Site-of-Service Differential: Between \$100,000 - \$200,000

CSAPH Report(s)

- 01* Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals: Minimal
- 02* FDA Expedited Review Programs and Processes: Minimal

HOD Comm on Compensation of the Officers

- 01* Report of the House of Delegates Committee on Compensation of the Officers: Maximum annual stipend estimated at \$87,000

Joint Report(s)

CMS-CSAPH 01* Aligning Clinical and Financial Incentives for High-Value Care: \$6,000

Report of the Speakers

- 01 Recommendations for Policy Reconciliation: Minimal

Resolution(s)

- 001 Support of a National Registry for Advance Directives: Modest
- 002* Protecting the Integrity of Public Health Data Collection: Modest
- 003* Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children: Modest
- 201 Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application: Modest
- 202 Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings: Modest
- 203 Support for the Development and Distribution of HIPAA-Compliant Communication Technologies: Minimal
- 204 Restriction on IMG Moonlighting: Modest
- 205 Legalization of the Deferred Action for Legal Childhood Arrival (DALCA): Modest
- 206 Repealing Potential Penalties Associated with MIPS: Modest
- 207 Defense of Affirmative Action: Minimal
- 208 Increasing Access to Broadband Internet to Reduce Health Disparities: Minimal
- 209 Sexual Assault Education and Prevention in Public Schools: Minimal
- 210 Forced Organ Harvesting for Transplantation: Modest
- 211 Eliminating Barriers to Automated External Defibrillator Use: Modest
- 212 Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings: Modest
- 213 Increasing Firearm Safety to Prevent Accidental Child Deaths: Minimal
- 214 A Public Health Case for Firearm Regulation: Minimal
- 215* Extending the Medical Home to Meet Families Wherever They Go: Modest
- 216* Medicare Part B Competitive Acquisition Program (CAP): Modest
- 217* Opposition to Medicare Part B to Part D Changes: Modest
- 218* Alternatives to Tort for Medical Liability: Modest
- 219* Promotion and Education of Breastfeeding: Modest

SUMMARY OF FISCAL NOTES (I-18)

Resolution(s)

- 220* Supporting Mental Health Training Programs for Corrections Officers and Crisis Intervention Teams for Law Enforcement: Minimal
- 221* Regulatory Relief from Burdensome CMS "HPI" EHR Requirements: Modest
- 222* Patient Privacy Invasion by the Submission of Fully Identified Quality Measure Data to CMS: Modest
- 223* Permanent Reauthorization of the State Children's Health Insurance Program: Modest
- 224* Fairness in the Centers for Medicare and Medicaid Services Authorized Quality Improvement Organization's (QIO) Medical Care Review Process: Modest
- 225* Surprise Out of Network Bills: Modest
- 226* Support for Interoperability of Clinical Data: Modest
- 227* CMS Proposal to Consolidate Evaluation and Management Services: Modest
- 603* Support of AAIP's Desired Qualifications for Indian Health Service Director: Minimal
- 801 Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle: Minimal
- 802 Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk): Estimated cost associated with developing educational content within the AMA's education platform requiring consultant and a vendor to produce the content.
- 803 Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of "Dense Breasts" on Mammogram: Minimal
- 804 Arbitrary Documentation Requirements for Outpatient Services: Modest
- 805 Prompt Pay: Minimal
- 806* Telemedicine Models and Access to Care in Post-Acute and Long-Term Care: Modest
- 807* Emergency Department Copayments for Medicaid Beneficiaries: Minimal
- 808* The Improper Use of Beers or Similar Criteria and Third-Party Payer Compliance Activities (H-185.940): Modest
- 809* Medicaid Clinical Trials Coverage: Modest
- 810* Medicare Advantage Step Therapy: Modest
- 811* Infertility Benefits for Active-Duty Military Personnel: Modest
- 812* ICD Code for Patient Harm from Payer Interference: not yet determined
- 813* Direct Primary Care Health Savings Account Clarification: Modest
- 814* Prior Authorization Relief in Medicare Advantage Plans: Modest
- 815* Uncompensated Physician Labor: Minimal
- 816* Medicare Advantage Plan Inadequacies: Modest
- 817* Increase Reimbursement for Psychiatric Services: Minimal
- 818* Drug Pricing Transparency: Modest
- 819* Medicare Reimbursement Formula for Oncologists Administering Drugs: Modest
- 820* Ensuring Quality Health Care for Our Veterans: Modest
- 821* Direct Primary Care and Concierge Medicine Based Practices: Modest
- 901 Support for Preregistration in Biomedical Research: Minimal
- 902 Increasing Patient Access to Sexual Assault Nurse Examiners: Minimal
- 903 Regulating Front-of-Package Labels on Food Products: Minimal
- 904 Support for Continued 9-1-1 Modernization and the National Implementation of Text-to-911 Service: Minimal
- 905 Support Offering HIV Post Exposure Prophylaxis to all Survivors of Sexual Assault: Minimal
- 906 Increased Access to Identification Cards for the Homeless Population: Minimal
- 908 Increasing Accessibility to Incontinence Products: Minimal
- 911 Regulating Tattoo and Permanent Makeup Inks: Modest
- 912 Comprehensive Breast Cancer Treatment: Minimal

SUMMARY OF FISCAL NOTES (I-18)

Resolution(s)

- 913 Addressing the Public Health Implications of Pornography: Minimal
- 914 Common Sense Strategy for Tobacco Control and Harm Reduction: Modest
- 915* Mandatory Reporting: Minimal
- 916* Ban on Tobacco Flavoring Agents with Respiratory Toxicity: Minimal
- 917* Protect and Maintain the Clean Air Act: Minimal
- 918* Allergen Labeling on Food Packaging: Minimal
- 919* Opioid Mitigation: Estimated cost of \$130K to implement resolution includes evaluation, review and report development detailing programs in Huntington, WV and Clark County, IN. Estimate includes staff time, travel and professional fees.
- 920* Continued Support for Federal Vaccination Funding: Modest
- 921* Food Environments and Challenges Accessing Healthy Food: Minimal
- 951 Prevention of Physician and Medical Student Suicide: Minimal
- 952 IMG Section Member Representation on Committees/Task Forces/Councils: Minimal
- 953 Support for the Income-Driven Repayment Plans: Modest
- 954 VHA GME Funding: Modest
- 955 Equality for COMLEX and USMLE: Modest
- 956 Increasing Rural Rotations During Residency: Modest
- 957 Board Certifying Bodies: Estimated cost of \$30,000 includes staff time and travel and meeting expenses
- 958* National Health Service Corps Eligibility: Modest
- 959* Physician and Medical Student Mental Health and Suicide: not yet determined
- 960* Inadequate Residency Slots: Modest
- 961* Protect Physician-Led Medical Education: Modest
- 962* Improve Physician Health Programs: Minimal

Resolutions not for consideration

- 601 Creation of an AMA Election Reform Committee: Estimated cost between 15\$ - \$25K (for 1 - 2 meetings depending on logistical arrangements includes travel and meeting costs, and staff time.
- 602* AMA Policy Statement with Editorials: not yet determined
- 907 Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing: Minimal
- 909 Use of Person-Centered Language: Minimal
- 910 Shade Structures in Public and Private Planning and Zoning Matters: Minimal

*** included in the Handbook Addendum**

Minimal - less than \$1,000

Modest - between \$1,000 - \$5,000

Moderate - between \$5,000 - \$10,000

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

14 Protection of Physician Freedom of Speech

CEJA Report(s)

01* Competence, Self-Assessment and Self-Awareness

02* Study Aid-in-Dying as End-of-Life Option / The Need to Distinguish "Physician-Assisted Suicide" and "Aid-in-Dying"

03* Amendment to E-2.2.1, "Pediatric Decision Making"

04* CEJA Role in Implementing H-140.837, "Anti-Harassment Policy"

05* Physicians' Freedom of Speech

Resolution(s)

001 Support of a National Registry for Advance Directives

002* Protecting the Integrity of Public Health Data Collection

003* Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-I-18

Subject: Protection of Physician Freedom of Speech
(Resolution 5-I-17)

Presented by: Jack Resneck, Jr. MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Todd M. Hertzberg, MD, Chair)

1 INTRODUCTION

2
3 Resolution 5-I-17, introduced by the American Academy of Pain Medicine (AAPM), consisted of
4 the following proposals:

5
6 RESOLVED, That our American Medical Association strongly oppose litigation challenging
7 the exercise of a physician's First Amendment right to express good faith opinions regarding
8 medical issues; and be it further
9

10 RESOLVED, That our AMA's House of Delegates encourage the AMA Litigation Center to
11 provide such support to a constituent or component medical society whose members have been
12 sued for expressing good faith opinions regarding medical issues as the Litigation Center
13 deems appropriate in any specific case.
14

15 The reference committee heard testimony that physicians had been sued for expressing their
16 opinions on such politically sensitive issues as the treatment of chronic pain or the potential
17 benefits of medical marijuana. Physicians testified that these lawsuits are expensive, produce
18 anxiety, and impact physicians' willingness to speak publicly on controversial public issues. While
19 testimony generally supported the resolution, concerns were raised regarding the term "good faith,"
20 which the reference committee found to be "a complex and sensitive issue." The resolution was
21 referred to the Board of Trustees in order to investigate the optimal language needed to accomplish
22 the goals of Resolution 5.
23

24 This report is submitted in response to that referral. Notably, though, the scope of the House
25 referral and thus of this report is much narrower than the heading, "Protection of Physician
26 Freedom of Speech," might suggest. Physician freedom of speech encompasses far more than the
27 subject of Resolution 5. In conformity with the Board's interpretation of the request from the
28 House, this report is focused on the specific proposals of Resolution 5 and particularly on the term
29 "good faith."
30

31 FIRST RESOLVE

32
33 The Board believes that the term "good faith" should be omitted from AMA policy based on the
34 first resolve of Resolution 5. Thus, AMA policy would appropriately read as follows:

1 RESOLVED, That our American Medical Association strongly oppose litigation challenging
2 the exercise of a physician's First Amendment right to express opinions regarding medical
3 issues.
4

5 The problem with the "good faith" limitation is that there is no simple test of whether a specific
6 opinion has been made in good faith or in bad faith. For example, suppose a physician were to
7 opine on a medical issue without disclosing that the physician's interests were financially
8 conflicted regarding that issue. As another example, suppose a physician were to advocate for a
9 specific treatment option, but the physician had previously recommended a different option and
10 failed to acknowledge this discrepancy. As a third example, suppose a lawsuit were brought against
11 a physician because of the physician's opinion on a medical issue, and the lawsuit, without setting
12 forth a further basis for the statement, alleged that the opinion had been rendered in "bad faith."
13 Each of these examples might suggest that the physician's opinion lacked good faith, but the
14 ultimate determination of that issue would require a much fuller factual development than has been
15 set forth.
16

17 AAPM introduced Resolution 5 to protect physicians' First Amendment right to express opinions.
18 A tenet of First Amendment law is that expression of opinions should be encouraged, and the bad
19 faith ones will be ultimately discredited in the "marketplace of ideas." The truth will prevail.
20 *McCullen v. Coakley*, 134 S. Ct. 2518, 2529 (2014). If the AMA is to stand behind the right of free
21 expression, it should not be undercut by a policy requiring that it ascertain at some point whether a
22 physician's opinion has been expressed in good faith.
23

24 If the first resolve of Resolution 5 is modified as suggested, it will be similar, but not quite
25 identical, to existing Policy H-460.895, "Free Speech Applies to Scientific Knowledge," which
26 states as follows: "Our AMA will advocate that scientific knowledge, data, and research will
27 continue to be protected and freely disseminated in accordance with the U.S. First Amendment."
28

29 SECOND RESOLVE

30

31 The Board believes that the second resolve of Resolution 5 would be undesirable. During the June
32 2017 Open Meeting of the Litigation Center, AAPM publicly discussed the abusive litigation
33 which led to Resolution 5. Thus, the Litigation Center is aware of the problem and is already
34 committed to taking whatever appropriate steps may be available to assist AAPM and its members.
35

36 Unfortunately, the problems AAPM faces are not, at least presently, readily susceptible to
37 assistance from the Litigation Center. Abusive litigation must be combatted under the procedures
38 available through the legal system. The Litigation Center has communicated closely with AAPM to
39 ascertain the point at which assistance might be helpful. The various lawsuits that have been
40 brought against AAPM and its members have simply not reached that point – if the point will ever
41 be reached.
42

43 As it happens, though, adoption of the first resolve, with the modification suggested above (*viz.*,
44 deletion of the "good faith" requirement), will increase the likelihood that the Litigation Center will
45 ultimately be able to support AAPM. In other words, the Litigation Center would find it difficult to
46 support AAPM if it had to convince itself that the physicians in question had written or spoken in
47 good faith. With the removal of the good faith impediment, the Litigation Center can premise its
48 support on the general principle of protecting free speech, without a detailed analysis of the facts
49 underlying a specific case.

1 The Board and the Litigation Center appreciate that AAPM has been respectful of the discretion
2 accorded to the Litigation Center. Nevertheless, the second resolve suggests that the Litigation
3 Center might benefit from additional encouragement from the House of Delegates. Such
4 encouragement, in this situation, would be unnecessary and might undercut the ability of the
5 Litigation Center to act according to its determination of how the interests of the AMA can be best
6 served through advocacy in the courts.

7
8 RECOMMENDATION

9
10 The Board of Trustees recommends that the following be adopted in lieu of Resolution 5-I-17 and
11 the remainder of this report be filed:

- 12
13 1. That our American Medical Association strongly oppose litigation challenging the exercise of a
14 physician's First Amendment right to express opinions regarding medical issues. (New HOD
15 Policy); and
16
17 2. That AMA Policy H-460.895, "Free Speech Applies to Scientific Knowledge," be reaffirmed
18 (Reaffirm HOD Policy).

Fiscal Note: Less than \$500

REPORT 1 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (1-I-18)
Competence, Self-Assessment and Self-Awareness
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

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

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

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

To fulfill their ethical responsibility of competence, physicians at all stages in their professional lives should cultivate and exercise skills of self-awareness and active self-observation; take advantage of tools for self-assessment that are appropriate to their practice settings and patient populations; and be attentive to environmental and other factors that may compromise their ability to bring their best skills to the care of individual patients. As a profession, medicine should provide meaningful opportunity for physicians to hone their ability to be self-reflective.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-I-18

Subject: Competence, Self-Assessment and Self-Awareness

Presented by: James E. Sabin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Todd M. Hertzberg, MD, Chair)

1 The expectation that physicians will provide competent care is central to medicine. This
2 expectation shaped the founding mission of the American Medical Association (AMA) and runs
3 throughout the AMA *Code of Medical Ethics* [1-4]. It undergirds professional autonomy and the
4 privilege of self-regulation granted to medicine by society [5]. The profession promises that
5 practitioners will have the knowledge, skills, and characteristics to practice safely and that the
6 profession as a whole and its individual members will hold themselves accountable to identify and
7 address lapses [6-9].

8
9 Yet despite the centrality of competence to professionalism, the *Code* has not hitherto examined
10 what the commitment to competence means as an ethical responsibility for individual physicians in
11 day-to-day practice. This report by the Council on Ethical and Judicial Affairs (CEJA) explores this
12 topic to develop ethics guidance for physicians.

13 14 DEFINING COMPETENCE

15
16 A caveat is in order. Various bodies in medicine undertake point-in-time, cross-sectional
17 assessments of physicians' technical knowledge and skills. However, this report is not concerned
18 with matters of technical proficiency assessed by medical schools and residency programs,
19 specialty boards (for purposes of certification), or hospital and other health care organizations (e.g.,
20 for privileging and credentialing). Such matters lie outside the Council's purview.

21
22 The ethical responsibility of competence encompasses more than knowledge and skill. It requires
23 physicians to understand that as a practical matter in the care of actual patients, competence is fluid
24 and dependent on context. Importantly, the ethical responsibility of competence requires that
25 physicians at all stages of their professional lives be able to recognize when they are and when they
26 are not able to provide appropriate care for the patient in front of them or the patients in their
27 practice as a whole. For purposes of this analysis, competence is understood as "the habitual and
28 judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values,
29 and reflection in daily practice for the benefit of the individual and the community being served"
30 and as "developmental, impermanent, and context dependent" [10].

31
32 Moreover, the Council is keenly aware that technical proficiency evolves over time—what is
33 expected of physicians just entering practice is not exactly the same as what is expected of mid-

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 career physicians or physicians who are changing or re-entering practice or transitioning out of
 2 active practice to other roles. Each phase of a medical career, from medical school through
 3 retirement, carries its own implications for what a physician should know and be able to do to
 4 practice safely and to maintain effective relationships with patients and with colleagues.

5
 6 The concept that informs this report differs as well from the narrower definition of competence as
 7 the knowledge and skills an individual has to do a job. Rather, this report explores a broader notion
 8 of competence that encompasses deeper aspects of wisdom, judgment and practice that enable
 9 physicians to assure patients, the public, and the profession that they provide safe, high quality care
 10 moment to moment over the course of a professional lifetime.

11 FROM SELF-ASSESSMENT TO “INFORMED” SELF-ASSESSMENT

12
 13
 14 Health care institutions and the medical profession as a whole take responsibility to regulate
 15 physicians through credentialing and privileging, routinely testing knowledge (maintenance of
 16 certification, requirements for continuing education, etc.) and, when needed, taking disciplinary
 17 action against physicians who fail to meet expectations for competent, professional practice.
 18 However, the better part of the responsibility to maintain competence rests with physicians’
 19 “individual capacity, as clinicians, to self-assess [their] strengths, deficiencies, and learning needs
 20 to maintain a level of competence commensurate with [their] clinical roles” [11].

21
 22 Self-assessment has thus become “integral to many appraisal systems and has been espoused as an
 23 important aspect of personal professional behavior by several regulatory bodies and those
 24 developing learning outcomes for students” [12]. Undergraduate and graduate medical education
 25 programs regularly use self-assessment along with third-party evaluations to ensure that trainees
 26 are acquiring the knowledge and skills necessary for competent practice [5,10,13-16].

27
 28 Yet how accurately physicians assess their own performance is open to question. Research to date
 29 suggests that there is poor correlation between how physicians rate themselves and how others rate
 30 them [5,12,13]. Various studies among health professionals have concluded that clinicians and
 31 trainees tend to assess their peers’ performance more accurately than they do their own; several
 32 have found that poor performers (e.g., those in the bottom quartile) tend to over-estimate their
 33 abilities while high performers (e.g., those in the top quartile), tend to under-estimate themselves
 34 [5,12,17].

35
 36 The available findings suggest that self-assessment involves an interplay of factors that can be
 37 complicated by lack of insight or of metacognitive skill, that is, ability to be self-observant in the
 38 moment. Similarly, personal characteristics (e.g., gender, ethnicity, or cultural background) and the
 39 impact of external factors (e.g., the purpose of self-assessment or whether it is designed to assess
 40 practical skills or theoretical knowledge) can all affect self-assessment [12,18]. The published
 41 literature also indicates that interventions intended to enhance self-assessment may seek different
 42 goals—improving the accuracy of self-assessors’ perceptions of their learning needs, promoting
 43 appropriate change in learning activities, or improving clinical practice or patient outcomes [12].

44
 45 Self-assessment tools alone are not sufficient measures of physicians’ ability to provide safe, high
 46 quality care. Feedback from third parties is essential—or as one researcher has observed, “The road
 47 to self-knowledge may run through other people” [19]. However, physicians are often wary of
 48 assessment. They have indicated that while they want feedback, they are not sure how to use
 49 information that is not congruent with their self-appraisals [20]. Physicians can be hesitant to seek
 50 feedback for fear of looking incompetent or exposing possible deficiencies or out of concern that
 51 soliciting feedback could adversely affect their relationships with those whom they approach [20].

1 They may also question the accuracy and credibility of the assessment process and the data it
 2 generates [21].
 3

4 To be effective, feedback must be valued both by those being assessed and by those offering
 5 assessment [14]. When there is tension between the stated goals of assessment and the implicit
 6 culture of the health care organization or institution, assessment programs can too readily devolve
 7 into an activity undertaken primarily to satisfy administrators that rarely improves patient care [20].
 8 Feedback mechanisms should be appropriate to the skills being assessed—multi-source reviews
 9 (“360° reviews”), for example, are generally better suited to providing feedback on communication
 10 and interpersonal skills than on technical knowledge or skills—and easy for evaluators to
 11 understand and use [14]. High quality feedback will come from multiple sources; be specific and
 12 focus on key elements of the ability being assessed; address behaviors rather than personality or
 13 personal characteristics; and “provide both positive comments to reinforce good behavior and
 14 constructive comments with action items to address deficiencies” [22]. Beyond such formal
 15 mechanisms, physicians should welcome and seek out informal input from colleagues. They should
 16 be willing to offer timely comments to colleagues as well.
 17

18 One study among physicians and physicians in training found that participants used a dynamic,
 19 multidimensional process to assess their own abilities. Under this process of what researchers
 20 identified as “informed self-assessment,” participants interpreted and responded to multiple types
 21 of information, such as cognitive and affective data, from both formal and informal sources [23].
 22 Participants described “critically reflecting ‘in action,’ that is, during an activity or throughout the
 23 day:”
 24

25 I think we do a lot of it without thinking of it as reflection. We do it every day when we look at
 26 a patient’s chart. You look back and see the last visit, “What did I do, or should I have done
 27 something different?” I mean that’s reflection, but yet I wouldn’t have thought of that as self-
 28 assessment or self-reflection, but we do it dozens of times a day [23].
 29

30 EXPERTISE & EXPERT JUDGMENT

31
 32 On this broad understanding of competence, physicians’ thought processes are as important as their
 33 knowledge base or technical skills. Thus, understanding competence requires understanding
 34 something of the nature of expertise and processes of expert reasoning, themselves topics of
 35 ongoing exploration [24,25,26,27]. Prevailing theory distinguishes “fast” from “slow” thinking;
 36 that is, reflexive, intuitive processes that require minimal cognitive resources versus deliberate,
 37 analytical processes that require more conscious effort [26]. Some scholars take expertise to
 38 involve “fast” processes, and specifically decision making that involves automatic, nonanalytic
 39 resources acquired through experience [24]. Others argue that expertise consists in using “slow,”
 40 effortful, analytic processes to address problems [24]. A more integrative view argues that
 41 expertise resides in being able to transition between intuitive and analytical processes as
 42 circumstances require. On this account, experts use automatic resources to free up cognitive
 43 capacity so that they maintain awareness of the environment (“situational awareness”) and can
 44 determine when to shift to effortful processes [24].
 45

46 Expert judgment is the ability “to respond effectively in the moment to the limits of [one’s]
 47 automatic resources and to transition appropriately to a greater reliance on effortful processes when
 48 needed” [24], a practice described as “slowing down.” Knowing when to slow down and be
 49 reflective has been demonstrated to improve diagnostic accuracy and other outcomes [26]. To
 50 respond to the unexpected events that often arise in a clinical situation, the physician must
 51 “vigilantly monitor relevant environmental cues” and use these as signals to slow down, to

transition into a more effortful state [25]. This can happen, for example, when a surgeon confronts an unexpected tumor or anatomical anomaly during a procedure. “Slowing down when you should” serves as a critical marker for intraoperative surgical judgment [24].

INFLUENCES ON CLINICAL REASONING

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

Heuristics

Physicians often use various heuristics—i.e., cognitive short cuts—to aid decision making. While heuristics can be useful tools to help physicians identify and categorize relevant information, these time-saving devices can also derail decision making. For example, a physician may mistakenly assume that “something that seems similar to other things in a certain category is itself a member of that category” (the representative heuristic) [28], and fail to diagnose a serious health problem. Imagine a case in which a patient presents with symptoms of a possible heart attack or a stroke that the physician proceeds to discount as stress or intoxication once the physician learns that the patient is going through a divorce or smells alcohol on the patient’s breath. Or a physician may miscalculate the likelihood of a disease or injury occurring by placing too much weight “on examples of things that come to mind easily, . . . because they are easily remembered or recently encountered” (the availability heuristic) [28]. For example, amidst heavy media coverage of an outbreak of highly infectious disease thousands of miles away in a remote part of the world, a physician seeing a patient with symptoms of what is actually a more commonplace illness may misdiagnose (or over diagnose) the exotic condition because that is what is top of mind.

Clinical reasoning can be derailed by other common cognitive missteps as well. These can include misperceiving a coincidental relationship as a causal relationship (illusory bias), or the tendency to remember information transferred at the beginning (or end) of an exchange but not information transferred in the middle (primary or recency bias) [28,29,30].

Habits of Perception

Like every other person, physicians can also find themselves prone to explicit (conscious) or implicit (unconscious) habits of perception or biases. Physicians may allow unquestioned assumptions based on a patient’s race or ethnicity, gender, socioeconomic status, or health behavior, among other features, to shape how they perceive the patient and how they engage with, evaluate and treat the individual. Basing one’s interactions with a patient on pre-existing expectations or stereotypes demeans the patient, undermines the patient’s relationship with the physician and the health care system, and can result in significant health disparities across entire communities [31]. This is of particular concern for patients who are members of minority and historically disadvantaged populations [31]. Physicians may fall victim to the tendency to seek out information that confirms established expectations or dismiss contradicting information that does not fit into predetermined beliefs (confirmatory bias) [28]. These often inadvertent thought processes can result in a physician pursuing an incorrect line of questioning or testing that then leads to a misdiagnosis or the wrong treatment.

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

Overconfidence

Finally, another obstacle to strong clinical reasoning that physicians may encounter is overconfidence. Despite their extensive training, physicians, like all people, are poor at identifying the gaps in their knowledge [28,30]. Physicians may consider their skills to be excellent, when, in fact, their peers have identified areas for improvement [30]. Overconfidence in one's abilities can lead to suboptimal care for a patient, be it through mismanaging resources, failing to consider the advice of others, or not acknowledging one's limits [28,30].

To avoid falling into such traps, physicians must recognize that many factors can and will influence their clinical decisions [28]. They need to be aware of the information they do and do not have and they need to acknowledge that many factors can and will influence their judgment. They should keep in mind the likelihood of diseases and conditions and take the time to distinguish information that is truly essential to sound clinical judgment from the wealth of possibly relevant information available about a patient. They should consider reasons their decisions may be wrong and seek alternatives, as well as seek to disprove rather than confirm their hypotheses [28]. And they should be sensitive to the ways in which assumptions may color their reasoning and not allow expectations to govern their interactions with patients.

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

Physicians' ability to practice safely can be affected by their own health, of course. The *Code of Medical Ethics* addresses such situations in guidance on physicians' health and wellness ([E-9.3.1](#)) and their responsibilities to impaired colleagues ([E-9.3.2](#)).

FROM INFORMED SELF-ASSESSMENT TO SELF-AWARENESS

Recognizing that many factors affect clinical reasoning and that self-assessment as traditionally conceived has significant shortcomings, several scholars have argued that a different understanding of self-assessment is needed, along with a different conceptualization of its role in a self-regulating profession [32]. Self-assessment, it is suggested, is a mechanism for identifying both one's weaknesses and one's strengths. One should be aware of one's weaknesses in order to self-limit practice in areas in which one has limited competence, to help set appropriate learning goals, and to identify areas that "should be accepted as forever outside one's scope of competent practice" [32]. Knowing one's strengths, meanwhile, allows a physician both to "act with appropriate confidence" and to "set appropriately challenging learning goals" that push the boundaries of the physician's knowledge [32].

If self-assessment is to fulfill these functions, physicians need to reflect on past performance to evaluate not only their general abilities but also specific completed performances. At the same time, they must use self-assessment predictively to assess how likely they are to be able to manage new challenges and new situations. More important, physicians should understand self-assessment as an ongoing process of monitoring tasks during performance [3]. The ability to monitor oneself in

the moment is critical to physicians' ethical responsibility to practice safely, at the top of their expertise but not beyond it.

Expert practitioners rely on pattern recognition and other automatic resources to be able to think and act intuitively. As noted above, an important component of expert judgment is transitioning effectively from automatic modes of thinking to more effortful modes as the situation requires. Self-awareness, in the form of attentive self-observation (metacognitive monitoring), alerts physicians when they need to direct additional cognitive resources to the immediate task. For example, among surgeons, knowing when to "slow down" during a procedure is critical to competent professional performance, whether that means actually stopping the procedure, withdrawing attention from the surrounding environment to focus more intently on the task at hand, or removing distractions from the operating environment [25].

Physicians should also be sensitive to the ways that interruptions and distractions, which are common in health care settings, can affect competence in the moment [34,35], by disrupting memory processes, particularly the "prospective memory"—i.e., "a memory performance in which a person must recall an intention or plan in the future without an agent telling them to do so"—important for resuming interrupted tasks [35,36]. Systems-level interventions have been shown to help reduce the number or type of interruptions and distractions and mitigate their impact on medical errors [37].

A key aspect of competence is demonstrating situation-specific awareness in the moment of being at the boundaries of one's knowledge and responding accordingly [33]. Slowing down, looking things up, consulting a colleague, or deferring from taking on a case can all be appropriate responses when physicians' self-awareness tells them they are at the limits of their abilities. The capacity for ongoing, attentive self-observation, for "mindful" practice, is an essential marker of competence broadly understood:

Safe practice in a health professional's day-to-day performance requires an awareness of when one lacks the specific knowledge or skill to make a good decision regarding a particular patient This decision making in context is importantly different from being able to accurately rate one's own strengths and weaknesses in an acontextual manner. . . . Safe practice requires that self-assessment be conceptualized as repeatedly enacted, situationally relevant assessments of self-efficacy and ongoing 'reflection-in-practice,' addressing emergent problems and continuously monitoring one's ability to effectively solve the current problem [32].

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills [32]. Self-aware physicians are also alert to how external stressors—the death of a loved one or other family crisis, or the reorganization of their practice, for example—may be affecting their ability to provide care appropriately at a given time. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient's well-being.

MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME

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

1 A variety of strategies are available to physicians to support effective self-assessment and help
2 physicians cultivate the kind of self-awareness that enables them to “know when to slow down” in
3 day-to-day practice. One such strategy might be to create a portfolio of materials for reflection in
4 the form of written descriptions, audio or video recording, or photos of encounters with patients
5 that can provide evidence of learning, achievement and accomplishment [16] or of opportunities to
6 improve practice. A strength of portfolios as a tool for assessing one’s practice is that, unlike
7 standardized examinations, they are drawn from one’s actual work and require self-reflection [15].
8

9 As noted above, to be effective, self-assessment must be joined with input from others. Well-
10 designed multi-source feedback can be useful in this regard, particularly for providing information
11 about interpersonal behaviors [14]. Research has shown that a four-domain tool with a simple
12 response that elicits feedback about how well one maintains trust and professional relationships
13 with patients, one’s communication and teamwork skills, and accessibility offers a valid, reliable
14 tool that can have practical value in helping to correct poor behavior and, just as important,
15 consolidate good behavior [14]. Informal arrangements among colleagues to provide thoughtful
16 feedback will not have the rigor of a validated tool but can accomplish similar ends.
17

18 Reflective practice, that is, the habit of using critical reflection to learn from experience, is
19 essential to developing and maintaining competence across a physician’s practice lifetime [38]. It
20 enables physicians to “integrate personal beliefs, attitudes, and values in the context of professional
21 culture,” and to bridge new and existing knowledge. Studies suggest that reflective thinking can be
22 assessed, and that it can be developed, but also that the habit can be lost over time with increasing
23 years in practice [38].
24

25 “Mindful practice,” that is, being fully present in everyday experience and aware of one’s own
26 mental processes (including those that cloud decision making) [39], sustains the attitudes and skills
27 that are central to self-awareness. Medical training, with its fatigue, dogmatism, and emphasis on
28 behavior over consciousness, erects barriers to mindful practice, while an individual’s unexamined
29 negative emotions, failure of imagination, and literal-mindedness can do likewise. Mindfulness can
30 be self-taught, but for most it is most effectively learned in relationship with a mentor or guide.
31 Nonetheless, despite challenges, there are myriad ways physicians can cultivate mindfulness.
32 Meditation, which may come first to mind, is one, but so is keeping a journal, reviewing videos of
33 encounters with patients, or seeking insight from critical incident reports [39].
34

35 “Exemplary physicians,” one scholar notes, “seem to have a capacity for self-critical reflection that
36 pervades all aspects of practice, including being present with the patient, solving problems,
37 eliciting and transmitting information, making evidence-based decisions, performing technical
38 skills, and defining their own values” [39].
39

40 RECOMMENDATION

41

42 The Council on Ethical and Judicial Affairs recommends that the following be adopted and the
43 remainder of this report be filed:
44

45 The expectation that physicians will provide competent care is central to medicine. It
46 undergirds professional autonomy and the privilege of self-regulation granted by society. To
47 this end, medical schools, residency and fellowship programs, specialty boards, and other
48 health care organizations regularly assess physicians’ technical knowledge and skills.
49

50 However, as an ethical responsibility competence encompasses more than medical knowledge
51 and skill. It requires physicians to understand that as a practical matter in the care of actual

1 patients, competence is fluid and dependent on context. Each phase of a medical career, from
2 medical school through retirement, carries its own implications for what a physician should
3 know and be able to do to practice safely and to maintain effective relationships with patients
4 and with colleagues. Physicians at all stages of their professional lives need to be able to
5 recognize when they are and when they are not able to provide appropriate care for the patient
6 in front of them or the patients in their practice as a whole.

7
8 To fulfill the ethical responsibility of competence, individual physicians and physicians in
9 training should strive to:

- 10
11 (a) Cultivate continuous self-awareness and self-observation.
12
13 (b) Recognize that different points of transition in professional life can make different
14 demands on competence.
15
16 (c) Take advantage of well-designed tools for self-assessment appropriate to their practice
17 settings and patient populations.
18
19 (d) Seek feedback from peers and others.
20
21 (e) Be attentive to environmental and other factors that may compromise their ability to
22 bring appropriate skills to the care of individual patients and act in the patient's best
23 interest.
24
25 (f) Intervene in a timely and appropriate manner when a colleague's ability to practice
26 safely is compromised by impairment, in keeping with ethics guidance.

27
28 Medicine as a profession should continue to refine mechanisms for assessing knowledge and
29 skill and should develop meaningful opportunities for physicians and physicians in training to
30 hone their ability to be self-reflective and attentive in the moment.

(New HOD/CEJA Policy)

Fiscal Note: Less than \$500.

REFERENCES

1. American Medical Association Code of Medical Ethics. Principle I. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
2. American Medical Association Code of Medical Ethics. Opinion 11.2.1, Professionalism in health care systems. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
3. American Medical Association Code of Medical Ethics. Opinion 1.2.3, Consultation, referral and second opinions. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
4. American Medical Association Code of Medical Ethics. Opinion 1.1.6, Quality. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
5. Gordon MJ. A review of the validity and accuracy of self-assessments in health professions training. *Acad Med*. 1991;66:762–769.
6. American Medical Association Code of Medical Ethics. Principle II. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
7. American Medical Association Code of Medical Ethics. Opinion 9.4.2, Reporting incompetent or unethical behavior by colleagues. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
8. American Medical Association Code of Medical Ethics. Opinion 9.4.3, Discipline and medicine. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
9. American Medical Association Code of Medical Ethics. Opinion 8.6, Promoting patient safety. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
10. Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA*. 2002;287(2):226–235.
11. Epstein RM, Siegel DJ, Silberman J. Self-monitoring in clinical practice: a challenge for medical educators. *J Contin Educ Health Professions*. 2008;28(1):5–13.
12. Colthart I, Bagnall G, Evans A, et al. The effectiveness of self-assessment on the identification of learner needs, learner activity, and impact on clinical practice: BEME Guide no. 10. *Medical Teacher*. 2008;30:124–145.
13. DA, Mazmanian PE, Fordis M, et al. Accuracy of physician self-assessment compared with observed measures of competence: a systematic review. *JAMA*. 2006;296:1094–1102.
14. Whitehouse A, Hassell A, Bullock A, et al. 360 degree assessment (multisource feedback) of UK trainee doctors: field testing of team assessment behaviors (TAB). *Medical Teacher*. 2007;29:171–178.
15. O’Sullivan P, Greene C. Portfolios: possibilities for addressing emergency medicine resident competencies. *Acad Emerg Med*. 2002;9(11):1305–1309.
16. Leigh IW, Smith IL, Bebeau M, et al. Competency assessment models. *Professional Psychology: Research and Practice*. 2007;38(5):463–473.
17. Lipsett PA, Harris I, Downing S. Resident self-other assessor agreement: influence of assessor, competency, and performance level. *Arch Surg*. 2011;146(8):901–906.
18. Svirko E, Lambert T, Goldacre MJ. Gender, ethnicity and graduate status, and junior doctors’ self-reported preparedness for clinical practice: national questionnaire surveys. *J Royal Society Med*. 2014;107(2):66–74.
19. Dunning D. Strangers to ourselves? *The Psychologist*. 2006;19(10):600–603.

20. Mann K, van der Vleuten C, Eva K, et al. Tensions in informed self-assessment: how the desire for feedback and reticence to collect and use it can conflict. *Acad Med.* 2011;86(9):1120–1127.
21. Sargeant J, Mann K, Ferrier S. Exploring family physicians' reactions to multisource feedback: perceptions of credibility and usefulness. *Medical Education* 2005;39:497–504.
22. Jackson JL, Kay C, Jackson WC, Frank M. The quality of written feedback by attendings of internal medicine residents. *J Gen Intern Med.* 2015;30(7):973–978.
23. Sargeant J, Amson H, Chesluk B, et al. The processes and dimensions of informed self-assessment: a conceptual model. *Acad Med.* 2010;85:1212–1220.
24. Moulton CE, Regehr G, Mylopoulos M, MacRae HM. Slowing down when you should: a new model of expert judgment. *Acad Med.* 2007;82(10 Suppl):S109–S116.
25. Moulton C, Regehr G, Lingard L, et al. Slowing down to stay out of trouble in the operating room: remaining attentive in automaticity. *Acad Med.* 2010;85(10):1571–1577.
26. Croskerry P. Achieving quality in clinical decision making: cognitive strategies and detection of bias. *Acad Emerg Med.* 2002;9(11):1184–1204.
27. Sklar DP. How do we think? can we learn to think? *Acad Med.* 2014;89:191–193.
28. Klein JG. Five pitfalls in decisions about diagnosis and prescribing. *BMJ* 2005;330:781–784.
29. Croskerry P, Petrie DA, Reilly B, Tait G. Deciding about fast and slow decisions. *Acad Med.* 2014;89:197–200.
30. Kadar N. Peer review of medical practices: missed opportunities to learn. *AJOG.* 2014; Dec:596–601.
31. Cooper LA, Roter DL, Carson KA, et al. The association of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. *Am J Public Health.* 2012;102:979–987.
32. Eva KW, Regehr G. Self-assessment in the health professions: a reformulation and research agenda. *Acad Med.* 2005;80(10 Suppl):S46–S54.
33. Eva KW, Regehr G. Knowing when to look it up: a new conception of self-assessment ability. *Acad Med* 2007;82(10 Suppl): 581–584.
34. Rivera AJ, Karsh B-T. Interruptions and distractions in healthcare: review and reappraisal. *Qual Saf Health Care.* 2010;19(4):304–312.
35. Grundgeiger T, Sanderson P. Interruptions in health care: theoretical views. *Intl J Med Informatics* 2009;78:293–307.
36. Monsell S. Task switching. *TRENDS in Cog Sciences.* 2003;7(3).
37. Relihan E, O'Brien V, O'Hara S, et al. The impact of a set of interventions to reduce interruptions and distractions to nurses during medication administration. *Qual Saf Health Care.* 2010; May 28.
38. Mann K, Gordon J, MacLeod A. Reflection and reflective practice in health professions education: a systematic review. *Adv in Health Sci Educ.* 2009;14:595–621.
39. Epstein RM. Mindful practice. *JAMA.* 1999;282(9):833–839.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-I-18

Subject: Study Aid-in-Dying as End-of-Life Option
(Resolution 15-A-16)
The Need to Distinguish “Physician-Assisted Suicide” and “Aid in Dying”
(Resolution 14-A-17)

Presented by: James E. Sabin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Todd M. Hertzberg, MD, Chair)

At the 2016 Annual Meeting, the House of Delegates referred Resolution 15-A-16, “Study Aid-in-Dying as End-of-Life Option,” presented by the Oregon Delegation, which asked:

That our American Medical Association (AMA) and its Council on Judicial and Ethical Affairs (CEJA), study the issue of medical aid-in-dying with consideration of (1) data collected from the states that currently authorize aid-in-dying, and (2) input from some of the physicians who have provided medical aid-in-dying to qualified patients, and report back to the HOD at the 2017 Annual Meeting with recommendation regarding the AMA taking a neutral stance on physician “aid-in-dying.”

At the following Annual Meeting in June 2017, the House of Delegates similarly referred Resolution 14-A-17, “The Need to Distinguish between ‘Physician-Assisted Suicide’ and ‘Aid in Dying’” (presented by M. Zuhdi Jasser, MD), which asked that our AMA:

(1) as a matter of organizational policy, when referring to what it currently defines as ‘*Physician Assisted Suicide*’ avoid any replacement with the phrase ‘*Aid in Dying*’ when describing what has long been understood by the AMA to specifically be ‘*Physician Assisted Suicide*’; (2) develop definitions and a clear distinction between what is meant when the AMA uses the phrase ‘*Physician Assisted Suicide*’ and the phrase ‘*Aid in Dying*’; and (3) fully utilize these definitions and distinctions in organizational policy, discussions, and position statements regarding both ‘*Physician Assisted Suicide*’ and ‘*Aid in Dying*.’

This report by the Council on Ethical and Judicial Affairs addresses the concerns expressed in Resolutions 15-A-16 and 14-A-17. In carrying out its review of issues in this area, CEJA reviewed the philosophical and empirical literature, sought input from the House of Delegates through an I-16 educational program on physician-assisted suicide, an informal “open house” at A-17, and its I-17 Open Forum. The council wishes to express its sincere appreciation for participants’ contributions during these sessions and for additional written communications received from multiple stakeholders, which have enhanced its deliberations.

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

The council observes that the ethical arguments advanced today supporting and opposing “physician-assisted suicide” or “aid in dying” are fundamentally unchanged from those examined in CEJA’s 1991 report on this topic [1]. The present report does not rehearse these arguments again as such. Rather, it considers the implications of the legalization of assisted suicide in the United States since the adoption of Opinion E-5.7, “Physician-Assisted Suicide,” in 1994.

“ASSISTED SUICIDE,” “AID IN DYING,” OR “DEATH WITH DIGNITY”?

Not surprisingly, the terms stakeholders use to refer the practice of physicians prescribing lethal medication to be self-administered by patients in many ways reflect the different ethical perspectives that inform ongoing societal debate. Proponents of physician participation often use language that casts the practice in a positive light. “Death with dignity” foregrounds patients’ values and goals, while “aid in dying” invokes physicians’ commitment to succor and support. Such connotations are visible in the titles of relevant legislation in states that have legalized the practice: “Death with Dignity” (Oregon, Washington, District of Columbia), “Patient Choice and Control at the End of Life” (Vermont), “End of Life Options” (California, Colorado), “Our Care Our Choice Act” (Hawaii), and in Canada’s “Medical Aid in Dying.”

Correspondingly, those who oppose physician provision of lethal medications refer to the practice as “physician-assisted suicide,” with its negative connotations regarding patients’ psychological state and its suggestion that physicians are complicit in something that, in other contexts, they would seek to prevent. The language of dignity and aid, critics contend, are euphemisms [2]; their use obscures or sanitizes the activity. In their view such language characterizes physicians’ role in a way that risks construing an act that is ethically unacceptable as good medical practice [3]. Still others, meanwhile, argue that the choice by terminally ill patients to take action to end their own lives with the assistance of their physician is distinct from what is traditionally understood as “suicide” [4].

The council recognizes that choosing one term of art over others can carry multiple, and not always intended messages. However, in the absence of a perfect option, CEJA believes ethical deliberation and debate is best served by using plainly descriptive language. In the council’s view, despite its negative connotations [5], the term “physician assisted suicide” describes the practice with the greatest precision. Most importantly, it clearly distinguishes the practice from euthanasia [1]. The terms “aid in dying” or “death with dignity” could be used to describe either euthanasia or palliative/hospice care at the end of life and this degree of ambiguity is unacceptable for providing ethical guidance.

COMMON GROUND

Beneath the seemingly incommensurate perspectives that feature prominently in public and professional debate about writing a prescription to provide patients with the means to end life if they so choose, CEJA perceives a deeply and broadly shared vision of what matters at the end of life. A vision that is characterized by hope for a death that preserves dignity, a sense of the sacredness of ministering to a patient at the end of life, recognition of the relief of suffering as the deepest aim of medicine, and fully voluntary participation on the part of both patient and physician in decisions about how to approach the end of life.

Differences lie in the forms these deep commitments take in concrete decisions and actions. CEJA believes that thoughtful, morally admirable individuals hold diverging, yet equally deeply held, and well-considered perspectives about physician-assisted suicide that govern how these shared commitments are ultimately expressed. For one patient, dying “with dignity” may mean accepting

the end of life however it comes as gracefully as one can; for another, it may mean being able to exercise some measure of control over the circumstances in which death occurs. For some physicians, the sacredness of ministering to a terminally ill or dying patient and the duty not to abandon the patient preclude the possibility of supporting patients in hastening their death. For others, not to provide a prescription for lethal medication in response to a patient's sincere request violates that same commitment and duty. Both groups of physicians base their view of ethical practice on the guidance of [Principle I](#) of the AMA *Principles of Medical Ethics*: "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."

So too, how physicians understand and act on the goals of relieving suffering, respecting autonomy, and maintaining dignity at the end of life is directed by identity-conferring beliefs and values that may not be commensurate. Where one physician understands providing the means to hasten death to be an abrogation of the physician's fundamental role as healer that forecloses any possibility of offering care that respects dignity, another in equally good faith understands supporting a patient's request for aid in hastening a foreseen death to be an expression of care and compassion.

IRREDUCIBLE DIFFERENCES IN MORAL PERSPECTIVES ON PHYSICIAN-ASSISTED SUICIDE

How to respond when coherent, consistent, and deeply held beliefs yield irreducibly different judgments about what is an ethically permissible course of action is profoundly challenging. With respect to physician-assisted suicide, some professional organizations—for example, the American Academy of Hospice and Palliative Medicine [6]—have adopted a position of "studied neutrality." Positions of studied neutrality neither endorse nor oppose the contested practice, but instead are intended to respect that there are irreducible differences among the deeply held beliefs and values that inform public and professional perspectives [6,7], and to leave space open for ongoing discussion. Nonetheless, as a policy position, studied neutrality has been criticized as neither neutral or appropriate for organized medicine [8], and as being open to unintended consequences, including stifling the very debate it purports to encourage or being read as little more than acquiescence with the contested practice [9].

CEJA approaches the condition of irreducible difference from a different direction. In its 2014 report on exercise of conscience, the Council noted that "health care professionals may hold very different core beliefs and thus reach very different decisions based on those core beliefs, yet equally act according to the dictates of conscience. For example, a physician who chooses to provide abortions on the basis of a deeply held belief in protecting women's autonomy makes the same kind of moral claim to conscience as does a physician who refuses to provide abortion on the basis of respect for the sanctity of life of the fetus" [10].

Importantly, decisions taken in conscience are not simply idiosyncratic; they do not rest on intuition or emotion. Rather, such decisions are based on "substantive, coherent, and reasonably stable" values and principles [10]. Physicians must be able to articulate how those values and principles justify the action in question.

The ethical arguments offered for more than two decades by those who support and those who oppose physician participation in assisted suicide reflect the diverging "substantive, coherent, and reasonably stable" values and principles within the profession and the wider moral community. While supporters and opponents of physician-assisted suicide share a common commitment to "compassion and respect for human dignity and rights" (AMA [Principles of Medical Ethics](#), I),

they draw different moral conclusions from the underlying principle they share. As psychiatrist Harvey Chochinov observed with respect to the stakeholders interviewed by Canadian Supreme Court’s advisory panel on physician-assisted death, “neither those who are strongly supportive nor those who are opposed hold a monopoly on integrity and a genuine concern for the well-being of people contemplating end of life. Equally true: neither side is immune from impulses shaped more by ideology than a deep and nuanced understanding of how to best honor and address the needs of people who are suffering” [11].

THE RISK OF UNINTENDED CONSEQUENCES

From the earliest days of the debate, a prominent argument raised against permitting physician-assisted suicide has been that doing so will have adverse consequences for individual patients, the medical profession, and society at large. Scholars have cited the prospect that boundaries will be eroded and practice will be extended beyond competent, terminally ill adult patients; to patients with psychiatric disorders, children; or that criteria will be broadened beyond physical suffering to encompass existential suffering; or that stigmatized or socioeconomically disadvantaged patients will be coerced or encouraged to end their lives. Concerns have also been expressed that permitting the practice will compromise the integrity of the profession, undermine trust, and harm the physicians and other health care professionals who participate; and that forces outside medicine will unduly influence decisions.

The question whether safeguards—which in the U.S. jurisdictions that permit assisted suicide, restrict the practice to terminally ill adult patients who have decision-making capacity and who voluntarily request assisted suicide, along with procedural and reporting requirements—can actually protect patients and sustain the integrity of medicine remains deeply contested. Some studies have “found no evidence to justify the grave and important concern often expressed about the potential for abuse—namely, the fear that legalized physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups” [12], others question whether the available data can in fact support any such conclusions, finding the evidence cited variously flawed [13], inadequate [14], or distorted [15].

Although cross-cultural comparisons are problematic [16], current evidence from Europe does tell a cautionary tale. Recent findings from studies in Belgium and the Netherlands, both countries that permit euthanasia as well as physician-assisted suicide, mitigate some fears but underscore others [17]. For example, research in the Netherlands has found that “requests characterized by psychological as opposed to physical suffering were more likely to be rejected, as were requests by individuals who lived alone,” mitigating fears that “solitary, depressed individuals with potentially reversible conditions might successfully end their lives.” At the same time, however, among patients who obtained euthanasia or assisted suicide, nearly 4 percent “reported only psychological suffering.” At the level of anecdote, a description of a case of euthanasia in Belgium elicited widespread concern about the emergence of a “slippery slope” [18].

Studies have also raised questions about how effective retrospective review of decisions to provide euthanasia/assisted suicide is in policing practice [19,20]. A qualitative analysis of cases that Dutch regional euthanasia committees determined had not met legal “due care criteria” found that such reviews focus on procedural considerations and do not “directly assess the actual eligibility” of the patients who obtained euthanasia [19]. A separate study of cases in which psychiatric patients obtained euthanasia found that physicians’ reports “stated that psychosis or depression did or did not affect capacity but provided little explanation regarding their judgments” and that review committees “generally accepted the judgment of the physician performing EAS [euthanasia or physician-assisted suicide]” [20]. It remains an open question whether reviews that are not able to

1 assess physicians' reasoning truly offer the protection they are intended to provide. To the extent
 2 that reporting and data collection in states that permit physician-assisted suicide have similar
 3 limitations, oversight of practice may not be adequate.

4
 5 Medicine must learn from this experience. Where physician-assisted suicide is legalized,
 6 safeguards can and should be improved—e.g., “[t]o increase safeguards, states could consider
 7 introducing multidisciplinary panels to support patients through the entire process, including
 8 verifying consent and capacity, ensuring appropriate psychosocial counseling, and discussing all
 9 palliative and end-of-life options” [21]. Both the state and the medical profession have a
 10 responsibility to monitor ongoing practice in a meaningful way and to address promptly
 11 compromises in safeguards should any be discovered. It is equally important that strong practices
 12 be identified and encouraged across all jurisdictions that permit physicians to assist suicide. Health
 13 care organizations in California and Canada, for example, have shared richly descriptive reports of
 14 practices adopted in response to the recent legalization of “aid in dying” in those jurisdictions that
 15 seek to address concerns about quality of practice and data collection [22,23].

16
 17 Medicine must also acknowledge, however, that evidence (no matter how robust) that there have
 18 not yet been adverse consequences cannot guarantee that such consequences would not occur in the
 19 future. As a recent commentary noted, “[p]art of the problem with the slippery slope is you never
 20 know when you are on it” [17].

21 22 SAFEGUARDING DECISIONS AT THE END OF LIFE

23
 24 CEJA has found that just as there are shared commitments behind deep differences regarding
 25 physician-assisted suicide, there are also shared concerns about how to understand the available
 26 evidence. For example, in the council's recent Open Forum, both proponents and opponents of
 27 physician-assisted suicide observed that in the U.S., debate occurs against the backdrop of a health
 28 care system in which patients have uneven access to care, including access to high quality end-of-
 29 life care. They also noted that patients and physicians too often still do not have the conversations
 30 they should about death and dying, and that too few patients are aware of the range of options for
 31 end-of-life care, raising concern that many patients may be led to request assisted suicide because
 32 they don't understand the degree of relief of suffering state-of-the-art palliative care can offer.
 33 Participants who in other respects held very different views concurred as well that patients may be
 34 vulnerable to coercion, particularly patients who are in other ways disadvantaged; and expressed
 35 concern in common that forces external to medicine could adversely influence practice.

36
 37 These are much the same concerns the Institute of Medicine identified in its 2015 report, *Dying in*
 38 *America* [24]. They are concerns echoed in a February 2018 workshop on physician-assisted death
 39 convened by the National Academies of Science, Engineering and Medicine [25]. They underscore
 40 how important it is to understand *why* a patient requests assisted suicide as a starting point for care
 41 [26].

42
 43 Patient requests for assisted suicide invite physicians to have the kind of difficult conversations that
 44 are too often avoided. They open opportunities to explore the patient's goals and concerns, to learn
 45 what about the situation the individual finds intolerable and to respond creatively to the patient's
 46 needs other than providing the means to end life—by such means as better managing symptoms,
 47 arranging for psychosocial or spiritual support, treating depression, and helping the patient to
 48 understand more clearly how the future is likely to unfold [5,27]. Medicine as a profession must
 49 ensure that physicians are skillful in engaging in these difficult conversations and knowledgeable
 50 about the options available to terminally ill patients [28]. The profession also has a responsibility to
 51 advocate for adequate resources for end-of-life care [16,28], particularly for patients from

disadvantaged groups. The availability of assisted suicide where it is legal must not be allowed to interfere with excellent care at the end of life.

CONCLUSION

At the core of public and professional debate, the council believes, is the aspiration that every patient come to the end of life as free as possible from suffering that does not serve the patient's deepest self-defining beliefs and in the presence of trusted companions, including where feasible and when the patient desires, the presence of a trusted physician. As Timothy Quill noted more than 20 years ago, "dying patients do not have the luxury of choosing not to undertake the journey, or of separating their person from their disease" [27]. Decisions about how to approach the end of life are among the most intimate that patients, families, and their physicians make. Respecting the intimacy and the authenticity of those relationships is essential if our common ideal is to be achieved.

While supporters and opponents of physician-assisted suicide share a common commitment to "compassion and respect for human dignity and rights" ([AMA Principles of Medical Ethics](#), I), they draw different moral conclusions from the underlying principle they share. Where one physician understands providing the means to hasten death to be an abrogation of the physician's fundamental role as healer that forecloses any possibility of offering care that respects dignity, another in equally good faith understands supporting a patient's request for aid in hastening a foreseen death to be an expression of care and compassion.

RECOMMENDATION

The Council on Ethical and Judicial Affairs has reviewed the literature and received thoughtful input from numerous individuals and organizations to inform its deliberations, and is deeply grateful to all who shared their insights. CEJA engaged in extensive, often passionate discussion about how to interpret the *Code of Medical Ethics* in light of ongoing debate and the irreducible differences in moral perspectives identified above. The council recognized that supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity, but diverge in drawing different moral conclusions from those underlying values in equally good faith. The council further recognized that medicine must learn from experience of physician-assisted suicide, and must ensure that, where the practice is legal, safeguards are improved.

After careful consideration, CEJA concludes that in existing opinions on physician-assisted suicide and the exercise of conscience, the *Code* offers guidance to support physicians and the patients they serve in making well-considered, mutually respectful decisions about legally available options for care at the end of life in the intimacy of a patient-physician relationship.

The Council on Ethical and Judicial Affairs therefore recommends that the *Code of Medical Ethics* not be amended, that Resolutions 15-A-16 and 14-A-17 not be adopted and that the remainder of the report be filed.

Fiscal Note: None.

REFERENCES

1. Council on Ethical and Judicial Affairs. Decisions near the end of life. *JAMA* 1992;267:2229–2233.
2. Vamos MJ. Physician-assisted suicide: saying what we mean and meaning what we say. *ANZJP* 2012;46:84–86.
3. Herx L. Physician-assisted death is not palliative care. *Curr Oncol* 2015;22:82–83.
4. American Association of Suicidology. “Suicide” Is Not the Same as “Physician Aid in Dying”. November 12, 2017. Available at <http://www.suicidology.org/Portals/14/docs/Press%20Release/AAS%20PAD%20Statement%20Approved%2010.30.17%20ed%2010-30-17.pdf>. Accessed July 10, 2018.
5. Quill TE, Back AL, Block SD. Responding to patients requesting physician-assisted death: physician involvement at the very end of life. *JAMA* 2016;315:245–246.
6. American Academy of Hospice and Palliative Medicine. *Statement on Physician-Assisted Dying*, June 24, 2016. Available at <http://aahpm.org/positions/pad>. Accessed February 3, 2017.
7. Quill TE, Cassel CK. Professional organizations’ position statements on physician-assisted suicide: a case for studied neutrality. *Ann Intern Med* 2003;138:208–211.
8. Sulmasy DP, Finlay I, Fitzgerald F, et al. Physician-assisted suicide: why neutrality by organized medicine is neither neutral nor appropriate. *J Gen Intern Med*. 2018;33(8):1394–1399.
9. Johnstone M-J. Organization position statements and the stance of “studied neutrality” on euthanasia in palliative care. *J Pain Symptom Manage* 2012;44:896–907.
10. Crigger BJ, McCormick PW, Brotherton SL, Blake V. Report by the American Medical Association’s Council on Ethical and Judicial Affairs on physicians’ exercise of conscience. *J Clin Ethics* 2016;27:291–226.
11. Chochinov HM. Physician-assisted death in Canada. *JAMA* 2016;315:253–254.
12. Battin MP, van der Heide A, Ganzini L, van der Wal G, Onwuteaka-Philipsen B. Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in vulnerable groups. *J Med Ethics* 2007;33:591–597.
13. Finlay IG, George R. Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in vulnerable groups—another perspective on Oregon’s data. *J Med Ethics* 2010;37:171–174.
14. Golden M, Zoanni T. Killing us softly: the dangers of legalizing assisted suicide. *Disability and Health Journal* 2010;3:16–30.
15. U.S. Conference of Catholic Bishops. *Assisted Suicide Laws in Oregon and Washington: What Safeguards?* September 22, 2016. Available at http://www.usccb.org/search.cfm?site=newusccb&proxystylesheet=newusccb_frontend&q=assisted+suicide&lang=eng. Accessed October 27, 2016.
16. Ganzini L, Back AL. The challenge of new legislation on physician-assisted death. *JAMA Intern Med* 2016;176:427–428.
17. Lerner BH, Caplan AL. Euthanasia in Belgium and the Netherlands: on a slippery slope? *JAMA Intern Med* 2015;175:1640–1641.
18. Aviv R. The death treatment. *New Yorker*;2015:June 22.
19. Miller DG, Kim SYH. Euthanasia and physician-assisted suicide not meeting due care criteria in the Netherlands: a qualitative review of review committee judgments. *BMJ Open* 2017;7:e017628.
20. Doernberg SN, Peteet JR, KIM SYH. Capacity evaluation of psychiatric patients requesting assisted death in the Netherlands. *Psychosomatics* 2016;57:556–565.
21. Gostin LO, Roberts AE. Physician-assisted dying: a turning point? *JAMA* 2016;315:249–250.

22. Nguyen HQ, Gelman EJ, Bush TA, Lee JA, Kanter MH. Characterizing Kaiser Permanente Southern California's experience with the California End of Life Option Act in the first year of implementation [research letter]. *JAMA Intern Med* 2017;December 26.
23. Li M, Watt S, Escaf M, et al. Medical assistance in dying: implementing a hospital-based program in Canada. *N Engl J Med* 2017;376:2082–2088.
24. Institute of Medicine. *Dying in America: Improving Quality and Honoring Individual Preferences near the End of Life*. Washington, DC: The National Academies Press; 2015.
25. National Academies of Science, Engineering and Medicine. *Physician-Assisted Death: Scanning the Landscape and Potential Approaches*. Available at <https://www.nap.edu/download/25131#>. Accessed August 20, 2018.
26. Dzung E. Can growing popular support for physician-assisted death motivate organized medicine to improve end-of-life care? *J Gen Intern Med*. 2018;33:1209–1211.
27. Quill TE. Doctor, I want to die. will you help me? *JAMA* 1993;270:870–873.
28. Petrillo LA, Dzung E, Smith AK. California's End of Life Option Act: opportunities and challenges ahead. *J Gen Intern Med* 2016;31:828–829.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 3-I-18

Subject: Amendment to E-2.2.1, “Pediatric Decision Making”
(Resolution 3-A-16, “Supporting Autonomy for Patients with Differences of Sex Development [DSD]”)
(Resolution 13-A-18, “Opposing Surgical Sex Assignment of Infants with Differences of Sex Development”)

Presented by: James E. Sabin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Todd M. Hertzberg, MD, Chair)

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

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

Testimony regarding BOT 7-I-16 expressed concern about lack of expert insight into the medical complexities in treating differences of sex development in pediatric patients in its analysis and possible unintended consequences of its recommendations.

Resolution 13-A-18, “Opposing Surgical Sex Assignment of Infants with Differences of Sex Development,” brought by the Michigan Delegation, asked

That our American Medical Association oppose the assignment of gender binary sex to infants with differences in sex development through surgical intervention outside of the necessity of physical functioning for an infant and believes children should have meaningful input into any gender assignment surgery.

Noting that the issue was under study by the Council on Ethical and Judicial Affairs (CEJA), the House of Delegates referred this resolution so that the council could address it during its ongoing deliberations in this area.

This CEJA report provides ethics guidance for physicians in relation to the concerns expressed in Resolutions 3-A-16 and 13-A-18. The council is grateful for participants’ contributions during reference committee hearings and for additional written communications received from multiple stakeholders, which have greatly enhanced its deliberations.

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 CLARIFYING THE QUESTION

2
3 Resolutions 3-A-16 and 13-A-18 speak to clinical decisions that have enormous significance for
4 individual patients and families, decisions that also implicate socially and culturally sensitive issues
5 of embodiment, gender, and sexuality. Each asks AMA to endorse specific broadly framed
6 statements intentionally limiting the range of decisions physicians, patients, and families should
7 reach. Yet as multiple stakeholders have pointed out, the label “differences [or disorders] of sex
8 development” is problematic in that it encompasses a very broad range of conditions that carry
9 quite variable implications for patients’ immediate and longer-term health, making for an
10 extremely complex clinical picture overall [e.g., 1,2,3].

11
12 It is, moreover, a clinical picture in which the body of evidence available to inform decisions
13 remains both limited and contested in important ways. In part, this reflects the difficulty in
14 collecting data, given the relative rarity of these conditions and the sheer range of conditions
15 currently labeled “differences of sex development” [e.g., 4]. Importantly, it reflects divergence
16 among understandings of children’s physical and psychosocial development on which
17 stakeholders’ perspectives rest [e.g., 4,5,6,7,8,9].

18
19 Literature reviews that stakeholders have provided to help inform CEJA’s deliberations indicate
20 ongoing, significant differences in how the published evidence is interpreted [e.g., 1,10]. Concerns
21 have been expressed about not just the quantity, but also the quality of the data available to inform
22 clinical decisions, with questions raised about whether studies have asked the “right” question and
23 about how well the framing of key research questions and the methodology, sample size, and data
24 analysis support the conclusions drawn in a given study [e.g., 11]. Stakeholders concur on the need
25 for systematic, well-designed research to provide robust evidence on the long-term outcomes that
26 are meaningful to patients of different clinical approaches.

27
28 CEJA appreciates the challenge this state of affairs poses for families and physicians who strive to
29 make clinically well-informed decisions for individual children. Thoughtful stakeholders differ in
30 good faith, at times profoundly, about whether and at what developmental stage in the child’s life
31 intervention should be considered medically essential, preferred, or acceptable for children born
32 with differences of sex development. Despite these differences, stakeholders clearly share a deep
33 professional commitment to serving the best interest of pediatric patients.

34
35 However, to the extent that Resolutions 3-A-16 and 13-A-18 call on the council to address the lack
36 of clinical consensus, they seek guidance that is not within CEJA’s purview to offer. It is not the
37 council’s role to adjudicate clinical disagreement or to prescribe what manner of decision is
38 “correct” or “best,” but rather to clarify the values at issue and identify what factors must be
39 considered to arrive at an *ethically sound* decision in any given patient’s unique situation.

40 MAKING DECISIONS FOR PEDIATRIC PATIENTS

41
42
43 Health care decisions for pediatric patients necessarily have a different character than decisions for
44 adult patients. Decisions for children are made in the context of a three-way relationship among
45 patient, parents (or guardians), and physician rather than the patient-physician dyad typical of
46 decision making for most adult patients. Further, except for emancipated minors, who are
47 authorized to make their own health care decisions, or certain decisions that other minor patients
48 are permitted to make independently (e.g., [E-2.3.3](#), Confidential Care for Minors), decisions for
49 pediatric patients are made, not by the patient, but by parents/guardians acting on the patient’s
50 behalf. Finally, the substituted judgment standard for surrogate decision making on behalf of adult
51 patients is for the most part unavailable to those who make decisions for minors, insofar as

children, especially very young children, are unlikely to have formed settled views and preferences upon which substituted judgment could be based.

The Patient's "Best Interests"

Ethically, and legally, then, parents are expected to make health care decisions in their children's best interests. As the persons best positioned to understand their child's unique needs and interests, parents/guardians are asked to fulfill the dual responsibility of both protecting their children and, at the same time, empowering them and promoting development of the child's capacity to become an independent decision maker. Parents/guardians are expected to safeguard their children's physical health and well-being *and* to nurture their children's developing personhood and autonomy.

Best interests, and thus goals for care, then, should be understood broadly, as encompassing more than simply medical considerations. Parents/guardians are indeed expected to weigh the clinical benefits and risks of treatment alternatives, including the option of no treatment or the timing of interventions, but to do so against the broader background of likely impact on the child's psychosocial well-being, relationships within the family, and family resources and values. As CEJA noted in its original report on decisions for pediatric patients (2007), because families provide a child's usual, often only, source of support and care, the family's needs and interests can also be relevant to treatment decisions. The council further observed that, "If none of the reasonable alternatives the health care team recommends can be reconciled with the family's circumstances, deciding on the best course of treatment may be 'an exercise in psychosocial, as well as technical medical, expertise'" [12].

The Committee on Bioethics of the American Academy of Pediatrics similarly holds that best interest should be understood broadly, to encompass more than purely clinical considerations. The committee urges decision makers to "acknowledge the pediatric patient's emotional, social, and medical concerns along with the interests of the child's family in the process of medical decision making" [13]. However, the committee argues, the concept of "harm" may be a "more realistic standard" for decisions on behalf of pediatric patients, noting that,

The intent of the harm principle is not to identify a single course of action that is in the minor's interest or is the physician's preferred approach, but to identify a harm threshold below which parental decisions will not be tolerated ... [13].

Using the harm principle to inform choices for individual patients, including pediatric patients, requires that decision makers take into account the kind, degree and duration of foreseeable harms, as well as the likelihood of their occurrence.

Engaging Children in Care Decisions

Absent reason to believe otherwise, parents/guardians are understood to be best able to take a child's long-term interests to heart in reaching a decision about care and in general their decisions should be respected. But that does not mean children should have no role in the decision-making process. In its original report CEJA noted that "the ethical principle of respect for persons also applies to children" and urged physicians to seek pediatric patients' assent to decisions made on their behalf [12,13]. Assent, the council observed, "weighs a child's ability to understand options and potential outcomes and to communicate preferences" [12].

CEJA recognized that "the notion of assent can be applied most readily to adolescent patients," but instructed physicians to evaluate younger patients' "cognitive capacities and judgment to determine

if they can understand the risks and benefits of treatment” and to engage them accordingly in the decision-making process. Not all information is cognitively and emotionally appropriate for every pediatric patient, nor is it necessary to communicate all information about a diagnosis and proposed care all at once. As for any patient, physicians should assess the amount of information the individual is capable of receiving at a given time and tailor disclosure to meet patients’ needs, preferences, and ability to understand ([E-2.1.3](#), Withholding Information from Patients).

Respecting children as (developing) persons also entails seeking to understand their reasons for disagreeing with treatment decisions. When an intervention is not immediately necessary to safeguard the child’s welfare, CEJA has argued, physicians (and parents/guardians) should respect a child’s refusal to assent to proposed treatment. Even when immediate treatment is essential to preserve well-being, physicians should explore the child’s reason for dissent, when circumstances permit. The more mature a minor patient is, the better able to understand what a decision will mean, and the more clearly the child can communicate preferences, the stronger the ethical obligation to engage young patients in decisions about their own care. As CEJA noted in refining its guidance on decisions for pediatric patients in 2010, communicating even sensitive and potentially frightening information—about HIV status or a terminal diagnosis, for example—can improve a child’s well-being [14].

Preserving Future Choices

In fulfilling their responsibility to nurture their children’s developing capacity to make autonomous decisions, parents/guardians are expected to make health care decisions that will least impinge on children’s opportunity to make important life choices themselves in the future. In general, decisions taken now on a child’s behalf should be made with an eye not to foreclose decisions the child can reasonably be expected, in time, to want and be able to make independently, realizing that choosing *not* to have a treatment or procedure performed also forecloses a future choice. This “right to an open future” is not absolute, of course. Parents/guardians must balance their responsibility to preserve the child’s opportunity for future exercise of self-determination with the need to protect the child’s immediate well-being. Physicians should be prepared to support them in that process, providing the best available data to inform their decision and directing them to appropriate psychosocial and other resources.

Finally, the opportunity to meet with and learn from others who have faced similar decisions can provide valuable firsthand insight and support that clinicians themselves may not be able to offer. Physicians should familiarize themselves with local peer support groups as resources to help inform decision making by parents and their minor children.

A CONTINUUM OF DECISIONS

The degree of difficulty faced by parents/guardians in making well-considered, ethically justifiable decisions for young patients who are not able to make their own health care choices varies across a continuum. At one end of that continuum are decisions that involve interventions about which there is consensus in the professional community, whose benefits are significant, supported by robust evidence, and significantly outweigh the risks they pose (the likelihood and magnitude of which are themselves well understood). In those situations, physicians have a responsibility to persuade reluctant parents/guardians to accept the intervention on their child’s behalf. Where the intervention would preserve life or avert serious harm and disagreement persists despite efforts to resolve the tension, physicians have legal and ethical obligations to seek court interventions against parental refusal of treatment.

At the other end are decisions that involve interventions that carry significant risk of harm or that currently available evidence would suggest offer little prospect of clinical benefit or cannot reasonably be expected to achieve the intended goal. In these cases, physicians have a responsibility to dissuade parents/guardians from pursuing the intervention, especially when it is irreversible, and should decline to provide the requested care when a patient's parents/guardian persist, in keeping with ethics guidance (e.g., [E-5.5](#), Medically Ineffective Interventions).

Between are decisions that involve interventions about which physicians may in good faith reach diverging professional judgments, and for which evidence as to short- and long-term benefit and risk is limited, equivocal, or contested. In such situations, how physicians interpret available evidence and its implications for an individual patient is shaped in significant part by their understanding of how to balance the competing values of beneficence and respect in upholding medicine's foundational commitment to serve the patient's (best) interests. In this "grey zone" physicians are challenged to negotiate with decision makers a shared agreement about how to understand this patient's medical and psychosocial interests and what plan of care will best serve those interests in the individual's unique circumstances and in most cases should give great deference to parental preferences.

SHOULD DECISIONS ABOUT DSD BE DIFFERENT FROM OTHER DECISIONS?

Helping parents/guardians make decisions for young patients with differences of sex development is inescapably challenging given the range of conditions at issue and the physiological/clinical complexity of many of those conditions. The fact that DSDs are entangled with socially and culturally sensitive issues of bodies, genders, and sex compounds that challenge—the more so in an environment in which a binary understanding of sex and gender is increasingly contested.

Yet whether these decisions are more challenging than decisions for pediatric patients with other diagnoses—say, decisions about cochlear implants for congenitally deaf newborns—is far from clear. The specific interventions about which decisions must be made and the timing of those decisions will be sensitive to the child's clinical situation, of course, but the fundamental task facing parents/guardians and physicians will still be to agree on a path forward that balances safeguarding the child's well-being, short and longer term, and nurturing the child's development as an individual with capacity to make decisions autonomously.

Regardless of the specific decision at issue, it is important that parents/guardians and physicians appreciate the fact that a pediatric patient will of necessity live out the consequences of a choice made by others—one with which the individual may ultimately come to disagree. Moreover, when decisions implicate issues that are socially and culturally divisive, such as sex assignment and "normalizing" surgery for DSD patients, patients and their families can be thrust into the role of agent of social change or preserver of the status quo, knowingly, willingly, or otherwise [4]. Ensuring that parents/guardians have the information and—absent immediate, life-threatening emergency—the time to make well-considered decisions is essential.

For physicians, supporting thoughtful, ethically sound decision making for all pediatric patients, especially very young patients, requires that they consider several fundamental questions and tailor recommendations to the individual's specific circumstances:

- What is this child's likely developmental course without (immediate) intervention? How strong is the evidence to support this prognosis?
- What are these parents/guardians' (and this patient's) overall goals for care?

- To what extent is the clinical anomaly a significant threat to health, immediately and in the long term?
- Is providing the proposed intervention at this stage in the child’s development supported by clear, high quality evidence?
- Could other interventions reasonably be staged developmentally to allow the patient and family time to gain experience living with the condition and to reflect on and perhaps adjust goals for care?
- To what extent would the proposed intervention (or lack of intervention) foreclose important life choices for the adolescent and adult the child will become? Are there reasonable alternatives that would address immediate clinical needs while preserving opportunity to make important future choices?
- What resources will the child and family need to support the child’s healthy physical and psychosocial development? How can the physician assist in making those resources available to the patient and family?

COMING TO COMMON GROUND

Parents/guardians are expected to make health care decisions in children’s “best interest.” In doing so, they are expected both to protect children and, at the same time, to empower children and promote children’s developing capacity to become independent decision makers. To nurture this developing capacity, health care decisions are preferable that will least impinge on children’s opportunity to make important life choices themselves in the future.

Making decisions for children that involve socially or culturally sensitive issues—for example, whether or how to discuss a terminal diagnosis with a child, or whether, when, or how to intervene medically for conditions that involve differences of sex development—is always challenging. The greater the uncertainty or lack of robust evidence supporting alternative courses of action, the more difficult the task becomes.

In such circumstances, despite a common commitment to serving the best interest of pediatric patients, thoughtful stakeholders may, in good faith, differ about whether a particular intervention, at a particular time is medically essential, preferred, or acceptable. When no single approach can be said a priori to be “best.” Ethically sound practice requires that decisions be carefully tailored for each patient in a process of shared decision making among parents/guardians, physician and the patient (in keeping with the child’s capacity to participate). Decision makers should seek a shared understanding of goals for care in creating a treatment plan that respects the unique needs, values, and preferences of the individual patient and family.

RECOMMENDATION

In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that Opinion E-2.2.1, “Pediatric Decision Making,” be amended by substitution as follows in lieu of Resolutions 3-A-16, “Supporting Autonomy for Patients with Differences of Sex Development (DSD),” and 13-A-18, “Opposing Surgical Sex Assignment of Infants with Differences of Sex Development,” and the remainder of this report be filed:

As the persons best positioned to understand their child’s unique needs and interests, parents (or guardians) are asked to fill the dual responsibility of protecting their children and, at the same time, empowering them and promoting development of children’s capacity to become independent decision makers. In giving or withholding permission for medical treatment for

1 their children, parents/guardians are expected to safeguard their children's physical health and
 2 well-being and to nurture their children's developing personhood and autonomy.

3
 4 But parents' authority as decision makers does not mean children should have no role in the
 5 decision-making process. Respect and shared decision making remain important in the context
 6 of decisions for minors. Thus, physicians should evaluate minor patients to determine if they
 7 can understand the risks and benefits of proposed treatment and tailor disclosure accordingly.
 8 The more mature a minor patient is, the better able to understand what a decision will mean,
 9 and the more clearly the child can communicate preferences, the stronger the ethical obligation
 10 to seek minor patients' assent to treatment. Except when immediate intervention is essential to
 11 preserve life or avert serious, irreversible harm, physicians and parents/guardians should
 12 respect a child's refusal to assent, and when circumstances permit should explore the child's
 13 reason for dissent.

14
 15 For health care decisions involving minor patients, physicians should:

- 16
 17 (a) Provide compassionate, humane care to all pediatric patients.
- 18
 19 (b) Negotiate with parents/guardians a shared understanding of the patient's medical and
 20 psychosocial needs and interests in the context of family relationships and resources.
- 21
 22 (c) Develop an individualized plan of care that will best serve the patient, basing treatment
 23 recommendations on the best available evidence and in general preferring alternatives that
 24 will not foreclose important future choices by the adolescent and adult the patient will
 25 become. Where there are questions about the efficacy or long-term impact of treatment
 26 alternatives, physicians should encourage ongoing collection of data to help clarify value to
 27 patients of different approaches to care.
- 28
 29 (d) Work with parents/guardians to simplify complex treatment regimens whenever possible
 30 and educate parents/guardians in ways to avoid behaviors that will put the child or others at
 31 risk.
- 32
 33 (e) Provide a supportive environment and encourage parents/guardians to discuss the child's
 34 health status with the patient, offering to facilitate the parent-child conversation for
 35 reluctant parents. Physicians should offer education and support to minimize the
 36 psychosocial impact of socially or culturally sensitive care, including putting the patient
 37 and parents/guardians in contact with others who have dealt with similar decisions and
 38 have volunteered their support as peers.
- 39
 40 (f) When decisions involve life-sustaining treatment for a terminally ill child, ensure that
 41 patients have an opportunity to be involved in decision making in keeping with their ability
 42 to understand decisions and their desire to participate. Physicians should ensure that the
 43 patient and parents/guardians understand the prognosis (with and without treatment). They
 44 should discuss the option of initiating therapy with the intention of evaluating its clinical
 45 effectiveness for the patient after a specified time to determine whether it has led to
 46 improvement and confirm that if the intervention has not achieved agreed-on goals it may
 47 be discontinued.
- 48
 49 (g) When it is not clear whether a specific intervention promotes the patient's interests, respect
 50 the decision of the patient (if the patient has capacity and is able to express a preference)
 51 and parents/guardians.

- 1 (h) When there is ongoing disagreement about patient's best interest or treatment
- 2 recommendations, seek consultation with an ethics committee or other institutional
- 3 resource.

(Modify Current HOD/CEJA Policy)

Fiscal Note: Less than \$500

REFERENCES

1. Joint communication from the American Urological Association, Societies for Pediatric Urology, American Association for Clinical Urologists, American Congress of Obstetricians and Gynecologists, Pediatric Endocrine Society, and North American Society for Pediatric and Adolescent Gynecology. March 7, 2018. See Appendix A.
2. Communication from Arlene B. Baratz, MD, on behalf of Androgen Insensitivity Syndrome—Differences of Sex Development (AIS-DSD) Support Group. September 14, 2018. See Appendix B.
3. Communication from Dina M. Matos, Executive Director, and Karen Lin Su, MD, Medical Director, CARESFoundation. September 4, 2018. See Appendix C.
4. Constitutional Court of Colombia. Sentencia SU-337/99, Parts I–III (in Spanish). Available at <http://www.isna.org/node/516>. Accessed August 28, 2018.
5. Communication from Kyle Knight, Researcher, Human Rights Watch. February 2, 2018. See Appendix D.
6. Communication from Homer Venters, MD, MS, Director of Programs, Physicians for Human Rights. February 1, 2018. See Appendix E.
7. Communication from Tara Demant, Director, Gender, Sexuality, and Identity Program, Amnesty International USA. February 21, 2018. See Appendix F.
8. Communication from Eliza Byard, PhD, Executive Director, GLSEN. January 31, 2018. See Appendix G.
9. American College of Pediatricians. *Gender Ideology Harms Children*, September 2017. Available at <https://www.acpeds.org/the-college-speaks/position-statements/gender-ideology-harms-children?highlight=gender%20ideology>. Accessed October 5, 2018.
10. Communication from Jerome Jeevaraj and Kieran McAvoy, Delegates, on behalf of the American Medical Association Medical Student Section. February 15, 2018. See Appendix H.
11. Baratz AB, Feder EK. Misrepresentation of evidence favoring early normalizing surgery for atypical sex anatomies [letter]. *Arch Sex Behav*. 2015; March 26. DOI 10.1007/s10508-015-0529-x.
12. American Medical Association. *Proceedings of the AMA House of Delegates*, Council on Ethical and Judicial Affairs Report 8-I-07, Pediatric Decision Making, November 2007. Available at http://ama.nmtvault.com/jsp/viewer.jsp?doc_id=ama_arch%252FHOD00005%252F00000005&view_wi_dth=640.0&rotation=0&queryI=&collection_filter=All&collection_name=Iee24daa-2768-4bff-b792-e4859988fe94&zoom_factor=current&search_doc=Pediatric%2520Decision%2520Making&sort_col=publication+date&highlightColor=yellow&color=&CurSearchNum=-1&search_docI=Pediatric+Decision+Making&page_name=&page_name=&submit.x=0&submit.y=0, pp. 120–125. Accessed October 5, 2018.
13. American Academy of Pediatrics, Committee on Bioethics. Informed consent in decision-making in pediatric practice. *Pediatrics* 2016;138(2):1–7. Available at <http://pediatrics.aappublications.org/content/early/2016/07/21/peds.2016-1484>. Accessed October 5, 2018.
14. American Medical Association. *Proceedings of the AMA House of Delegates*, Council on Ethical and Judicial Affairs Report 1-I-10, Pediatric Decision Making, November 2010. Available at http://ama.nmtvault.com/jsp/viewer.jsp?doc_id=ama_arch%252FHOD00006%252F00000003&view_wi_dth=640.0&rotation=0&queryI=&collection_filter=All&collection_name=Iee24daa-2768-4bff-b792-e4859988fe94&zoom_factor=current&search_doc=Pediatric%2520Decision%2520Making&sort_col=publication+date&highlightColor=yellow&color=&CurSearchNum=-1&search_docI=Pediatric+Decision+Making&page_name=&page_name=&submit.x=0&submit.y=0, pp. 65–69. Accessed October 5, 2018.

From: [Zwarick, Kathleen](#)
To: [Elliott Crigger](#)
Cc: ["Lucia DiVenere"](#); ["Lorraine O"Grady"](#); [Ally Lopshire](#); ["Lee, Peter"](#); [Stine, Bradley](#); [Kristan, Johnathon](#); ["Anne-Marie Amies"](#); [Sheppard, Mike](#)
Subject: CEJA DSD Report - Overview of Comments
Date: Wednesday, March 07, 2018 4:46:12 PM
Attachments: [CEJA Comments - DSD Report with Appendix -March 2018.docx](#)

Dear Elliott,

As you know, the urological societies convened with other medical societies with expertise in the area to discuss the AMA Council on Ethical and Judicial Affairs (CEJA) Report 3-I-17, "Supporting Autonomy for Patients with Differences of Sex Development (DSD)". The attached is a high-level overview that incorporates the redlined edits we shared with you throughout our conversations. These comments reflect the comprehensive communications between the American Urological Association, Societies for Pediatric Urology, American Association for Clinical Urologists (AACU), American Congress of Obstetricians and Gynecologists, American Academy of Child & Adolescent Psychiatry, North American Society for Pediatric and Adolescent Gynecology, The Endocrine Society, Pediatric Endocrine Society, GLMA: Health Professionals Advancing LGBT Equality, and Medical Students Section discussed. The Medical Students Section indicated that they will submitting a separate analysis of the literature you previously were handed before our February 28th call.

Prior to submitting this to you, the urological delegation circulated the document to the groups who provided redlined edits. The following groups reviewed the attachment and noted that it fairly reflected the discussions:

American Urological Association
Societies for Pediatric Urology
American Association for Clinical Urologists
American Congress of Obstetricians and Gynecologists
Pediatric Endocrine Society

The North American Society for Pediatric and Adolescent Gynecology (NASPAG) is reviewing the document.

We hope you find this useful for the discussions this week,
Kathy

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March 7, 2018

The Council on Ethical and Judicial Affairs
Attn: Elliott J. Crigger, CEJA Secretary
American Medical Association
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611

Re: CEJA Report 3-I-17, Supporting Autonomy for Patients with Differences of Sex Development

The following represents a high-level overview of the AMA Council on Ethical and Judicial Affairs (CEJA) Report 3-I-17, “Supporting Autonomy for Patients with Differences of Sex Development (DSD). The overview is a result of communications between the American Urological Association, Societies for Pediatric Urology, American Association for Clinical Urologists, American Congress of Obstetricians and Gynecologists, American Academy of Child & Adolescent Psychiatry, North American Society for Pediatric and Adolescent Gynecology, The Endocrine Society, Pediatric Endocrine Society, GLMA: Health Professionals Advancing LGBT Equality, and Medical Students Section discussed. It is our understanding that the Medical Students Section will be submitting a separate analysis of the literature.

I. A Note on Terminology: “DSD” versus “Intersex”

To use “DSD” (serving as an abbreviation for differences of sex development) in the Report could have overly broad implications for conditions that are not intended to be at issue for its purposes. DSD is highly heterogeneous, with each condition exhibiting its own spectrum of severity, and depending on the stakeholder, may include or exclude various conditions, ambiguous or not, affecting the genitalia. For example, DSD includes syndromes such as Turner’s and Klinefelter’s that usually do not include genital ambiguity and are more prevalent than syndromes involving genital ambiguity.

We believe that the AMA opinions issued in its Code of Medical Ethics should continue to meet the standard of broad application, and avoid providing specific clinical recommendations for DSD per se. As such, we believe that the term “DSD” as used in the Report ought to be replaced by a term that specifically denotes patients with intersexuality. That being said, however, for the purposes of simplicity and clarity, we will mimic the terminology used in the Report and continue to refer to these patients as patients with DSD in the following comments.

II. Gaps in the Report’s Literature Review

A. There are a number of additional references that are relevant to the Report that are not considered in the literature review or included in the bibliography.

As is evident in the additional references cited in the redlined report containing edits from various organizations, we believe that there are a number of additional references that are not included in the Report’s bibliography that are relevant to the analysis and would allow for a more complete literature review.¹ To name a few, it does not contain the latest references that address the considerable evidence for risk of social stigma associated with genital ambiguity or that survey the parents of affected patients,

¹ For a complete list of additional references, see *infra* Appendix A.

nor does it include the available articles related to all the surveys of samples of DSD patients showing the majority of adult patients queried favor surgery before the age of consent.

For example, after detailing the findings from a 2006 National Institute of Diabetes and Digestive and Kidney Diseases article on the lack of outcomes data regarding DSD patients, the Report goes on to note that “[a] decade later, outcomes data remain limited” (AMA Council on Ethical and Judicial Affairs, Report 3-I-17, 2017, p. 2 [hereinafter *CEJA Report*]). The Report’s reference to a “small study carried out in 2011–2012 among medical students in Zurich” that examined the impact of how physicians discussed treatment for a child with DSD on the choice for or against surgery is interesting, but it does not, however, address our increasing knowledge of outcomes, based on the current literature (*CEJA Report*, p. 2).

The available data, as noted in more detail in the Appendix, suggest that satisfactory outcomes occur, even in patients who underwent procedures prior to important refinements that have occurred in the past fifteen to twenty years. Results vary with diagnosis, genetic variant, and may be independent of surgery, in that those who do not have surgery may have unsatisfactory outcomes.² We propose that when revising the Report, the Council should consider including a brief review of the literature from the past decade regarding the available outcomes data.³

Similarly, the Report could also consider two opinions issued by the Constitutional Court of Colombia, which capture the complexities particularly with respect to social norms and ethical considerations when treating patients born with DSD/intersex. Importantly, the court rejected a “no surgery” moratorium by stating that it would force social experimentation by forcing children to be raised with genital ambiguity or genitalia contrary to their gender of rearing. In detailing the precedent set in the earlier case opinion on the same legal question in a similar case involving intersex surgery in infants, the Court noted:

This Court then assessed whether, due to the characteristics of the surgeries and hormonal interventions designed to reshape the genitals, these therapies should be postponed until the person can authorize them. The ruling concluded that the adoption of that extreme measure by a constitutional court was problematic, since there is also no evidence that these therapies in infants are in all cases harmful and unnecessary. On the contrary, there is evidence that these medical interventions have had positive effects in certain events... Therefore, the mandatory postponement of these surgeries until the person could consent could put these children and their parents in a difficult situation, because they should lead difficult social transformations to ensure spaces of tolerance for their unusual anatomy. *The prohibition of risky medical treatment without the consent of the person itself then translated into the implementation of an equally risky social experimentation, whose consequences for minors, that is the essential interest that this Court must protect, are unpredictable* (internal citations omitted; emphasis added).

² For an example of a more thorough review of outcomes data to include in the revised report, see *infra*, Appendix B.

³ Some of the outcomes data omitted include: Binet A, et al. Should we question early feminizing genitoplasty for patients with congenital adrenal hyperplasia and XX karyotype? *J Pediatr Surg.* 2016;51(3):465-468; Fagerholm R, et al. Sexual function and attitudes toward surgery after feminizing genitoplasty. *J Urol.* 2011;185(5):1900-1904; Nordenskjöld A, et al. Type of mutation and surgical procedure affect long-term quality of life for women with congenital adrenal hyperplasia. *J Clin Endocrinol Metab.* 2007;93(2):380-386. For a complete list of omitted references, see *infra*, Appendix A.

Sources like those highlighted above are critical to not only providing a complete review of the literature, but also to understanding the complexities and nuances involved in treating these patients.

B. Other conclusions could be drawn for certain literature referenced in the Report.

In addition to omitting some references, we believe that other conclusions or key points could be drawn from some of the literature the Report does include in its review. For example, the Report references a recent interviews conducted by Human Rights Watch, noting that the interviews “examine patient experience and underscore the value of organizing dedicated multidisciplinary care teams” (*CEJA Report*, p. 3). However, it should be recognized that these interviews are not scientifically representative of the full population of patients treated, and although anecdotes are powerful, scientific conclusions must be based on broad and systematic population studies.

Additionally, the Report notes that “DSD communities and a growing number of health care professionals have condemned such genital ‘normalizing,’ arguing that except in the rare cases in which DSD presents as life-threatening anomalies, genital modification should be postponed until the patient can meaningfully participate in decision making [5,8,9,10]” (*CEJA Report*, p. 3). However, the statements cited here, specifically Wiesemann (5) and Gillam (9), are not consistent with the sentence to which they refer. It would be much more accurate to instead state that health care professionals and ethicists recognize that medical decision-making in DSD/intersex should be individualized, taking into account multiple factors, including the child’s perspective, parental choice and the parent-child relationship, and psychosocial as well as physical risks to the child which may or may not be life-threatening or impact future fertility [5, 9]. The risk exists that “Postponing this decision [medical or surgical intervention] to the age of consent, however, means closing an important window of opportunity for the child. The future adult’s consent, thus, will be meaningless, because no decision will undo the consequences of a waiver of treatment in the past” [5]. Efforts to preserve the “child’s right to an open future” by postponing “genital modification” when the situation is not life-threatening, may instead adversely affect psychological, psychosocial or developmental health.

In all, given the gaps in the references considered in the Report as noted above, we urge the Council to undertake a more thorough review of the literature during the revision process.

III. **The Role of Medical Necessity and Informed Consent in Early Treatment Decisions**

Recently, there has been concern among certain groups that early surgical intervention is not always medically necessary—i.e. in cases of cosmetic surgeries, or in what is referred to as “gender normalizing” surgeries—and therefore it should be cautioned against as an option at least until the patient can give informed consent. However, given the complexity and highly individualized nature of this condition and that there is no general consensus on how to define medical necessity in this context, **we are strongly against a moratorium on early surgical intervention in infants as an umbrella policy, even if such a policy were restricted to cases of medical unnecessary.** In our opinion, there is simply no scientific evidence to support such a position, and it ultimately would hinder our ability to provide the highest quality of care to our patients.

A. The term “medically necessary” has been used in too narrow a context for children with DSD and is an insufficient standard at the present time.

We agree that it is important to “respect the decisions of the patient and parents/guardian when it is not clear whether a specific intervention promotes the patient’s best interest” (*CEJA Report*, p. 6). Assuredly, long-term, prospective randomized studies are lacking in this field, in large part due to the nature and marked heterogeneity of the conditions included under the DSD umbrella, the complexity of these conditions, and the logistical problems inherent in randomization and long-term follow-up. Although some adults have experienced unsatisfactory outcomes after surgery in childhood for DSD, others have outcomes that are equivalent to the general population, and the majority of adults queried in multiple studies express agreement with the option for early surgery. Limited data suggest that affected individuals can do “well” with psychosocial support, but other data suggest that affected individuals for whom surgery is postponed are subject to psychosocial harm. We believe that the term “medically necessary” has been used in too narrow a context for children with DSD. Based on the WHO definition of health, surgical treatment may be medically necessary to optimize not only physical but also psychological, psychosocial, and/or developmental health.

We also agree that with respect to DSD, “decisions about a child’s best interests and appropriate interventions involve sensitive issues of sex, gender, and sexuality, and interventions that may be irreversible” (*CEJA Report*, p. 4). However, we feel that any recommendations that specifically focus on these issues have the potential to generate unintended consequences that run the risk of being more generally harmful. This is particularly true in view of some efforts to consolidate many, unrelated conditions under a signal diagnosis, namely DSD. The heterogeneity of developmental conditions affecting the genitalia warrants adherence to an existing standard of individualized care.

For example, DSD presentations may range from a female with CAH who may be born with ovaries and a uterus but completely male external genitalia; ovotesticular DSD in which both gonads may be functional during early infancy, impacting gender development, genital development and potential fertility; and other diagnoses such as partial androgen insensitivity syndrome which involves the spectrum of essentially none to considerable androgen responsiveness within the central nervous system or reproductive organs, among others. Obstructive anomalies may not only impact fertility, but may result in urinary leakage due to urinary hydrocolpos, pain, and infection; early surgery may be alleviate these symptoms. Indeed, in recent years, advances in the field have helped to clarify which individuals are likely to benefit from early surgery, and those for whom such surgery is best delayed, although further outcome studies are needed.

In all, we believe that the scientific literature is clear that early surgery is potentially beneficial for a certain subset of patients. Unfortunately, there is no way to determine with any degree of certainty what that subset explicitly entails, and thus it is virtually impossible to come to a general consensus on how to concretely define medical necessity in the context of patients with DSD. As a result, until such a time that we are able to do so, we must continue not to take a “one size fits all” approach and instead treat each patient based on the patient’s individual needs.

B. Postponing surgery until the age of assent or consent poses additional concerns to adequate treatment and may negatively affect a patient’s future.

Ethicists in the field note that universal postponement of surgery to the age of consent—typically, but not necessarily, at age 18—may close a window of opportunity for the child that can negatively affect

that child's future. And while some may suggest that postponing surgery to the age of assent—which occurs at some arbitrary time during adolescent before the age of consent—is preferable, such a postponement is still problematic on its own. In the first place, determining the age of assent is highly difficult and varies across fields, treatment type, and even states. But even if there was a way to garner a consensus on the age of assent among the medical community for treatment of patients with DSD, this approach may still put patients who could best be served by intervention prior to the age of assent at a potentially significant disadvantage and facilitate psychosocial harm that, in some cases, will not be adequately addressed by psychosocial interventions. For example, fertility may be negatively impacted without surgical intervention for some conditions and therefore to delay surgery until the age of assent or consent may close a window of opportunity to optimize fertility for some patients.

In sum, an approach that requires patient assent or consent for surgical intervention, or any medical intervention for that matter, impinges upon the rights of patients who would otherwise benefit from care, and from the rights of their parents to make well-informed decisions for their children.

IV. Parental Rights and Informed Consent

We endorse the importance of parents in medical decision-making for their children that protects all rights, based on all available options; allows for individualized care; and protects physicians, surgeons and families who must struggle with these complex issues and decisions. The current treatment approach among the medical community seeks to respect both parental authority as well as the rights of the child and offer medical, non-surgical, and surgical options, when appropriate, for management in conjunction with multidisciplinary review of each individual case based on treatment standards.

A. The role of parents in the decision-making process is paramount to informed consent and an individualized treatment approach.

As is recognized in existing AMA policy, “decisions for pediatric patients usually involve a three-way relationship among the minor patient, the patient’s parents (or guardian), and the physician... parents or guardians are expected, and authorized, to provide or decline permission for treatment for minor patients” (*CEJA Report*, p. 5). However, as the Report correctly notes, we understand that treatment decisions and appropriate interventions for children with DSD involve complex issues of sex, gender, and sexuality, and there is a need to recognize the rights of the individual involved as best as possible.

As physicians who treat patients with DSD, we know that medical care requires respect for the individual, their parents, and their culture, and we are committed to the current as well as the future health and well-being of all children entrusted to our care. We also know that parents generally act in the best interest of their children and should be respected as their representatives, and should be allowed to make a well-informed, shared decision after extensively and repeatedly discussing all treatment options, including the risks and benefits of each choice, with the multidisciplinary team of physicians.

We respect both parental authority as well as the rights of the child and offer medical, non-surgical, and surgical options, when appropriate, for management in conjunction with multidisciplinary review of each individual case based on treatment standards. If surgery is considered, complete informed consent with counseling and support should be provided prior to proceeding with any surgical intervention. Each child's diagnosis and treatment options are presented to parents based on best available science.

True informed consent should include discussion of immediate risks and benefits, including those associated with early and late surgical intervention, as well as known and unknown long-term outcomes.

- B. The rapid evolution in the treatment approach underscores the need for a multidisciplinary approach that is transparent and includes open discussion of options with parents to determine the best course of action for the patient.

Evolving surgical approaches since 1999 that reflect advances in knowledge of genital anatomy and innervation may limit negative outcomes that are currently reported by some adults. Over the past two to three decades, there have been major shifts towards syndrome-specific and syndrome-severity-specific recommendations, both in policies of gender assignment (to reduce the risk of later gender dysphoria) and in techniques used in genital surgery to reduce adverse side effects (i.e., replacement of clitorrectomy by clitoral reduction surgery). In addition, there has been a clear trend towards caution with respect to genital surgery for psychosocial indications, with various guidelines recommending against such surgery in mild cases of genital atypicality and the performance of surgeries exclusively at centers of excellence with relatively high rates of such surgeries.

Multidisciplinary teams are now convened to treat a patient born with DSD and generally include experts in the areas of pediatric and reproductive endocrinology, genetics, urology, gynecology, psychiatry and cytogenetics with close involvement of family members. As a result of specialized training, surgery is performed in rare situations and after comprehensive evaluation and consideration of all the available evidence for the patient's best health and interests.

V. Conclusion

As highlighted above, there is simply no discernable set of circumstances under which early surgical intervention is never (or always, for that matter) appropriate. Based on the available data, neither total postponement of surgery to the age of consent nor performing surgery early is free of risk, and methods of risk quantification at this stage are too imperfect to allow a clear decision between the options. Under these circumstances, it is clear that joint decision-making on genital surgery and its timing between parents and physicians, after detailed thorough information has been provided to the parents about the likely effects and risks, is most appropriate. In all, we strongly believe that the need for a multidisciplinary approach that is transparent and includes open discussion of all options, including surgical as well as nonsurgical ones, with open disclosure about the potential complications is paramount to providing each patient with the highest quality care.

We appreciate the opportunity to provide comments on this important Report, and look forward to working with the Council throughout the revision process.

Encl: Appendix

APPENDIX A

Additional References: Supplemental Annotated Bibliography

Baskin LS., Erol A, Li YW, Liu WH, Kurzrock E, Cunha GR. Anatomical studies of the human clitoris. J Urol. 1999;162:1015-1020.

Binet A, Lardy H, Geslin D, Francois-Fiquet C, Poli-Merol ML. Should we question early feminizing genitoplasty for patients with congenital adrenal hyperplasia and XX karyotype? J Pediatr Surg. 2016;51(3):465-468. doi: 10.1016/j.jpedsurg.2015.10.004.

- Retrospective case study over 40 yrs.
 - 21 patients from 3 French Centers.
 - 3 parent-child controls for each patient.
 - Sex assigned at birth concordant with gender identity in 85.7%.
- None of the CAH patients identified themselves as male. No difference in sexual satisfaction between early and late surgical groups. Sexual satisfaction was higher than control groups (p<0.05).
- Significant difference in self-assessed gender morphotype between CAH patients and controls.
- Overall 90% of CAH patients (100% of early surgical group) and only 52% of controls believed that genitoplasty should be performed during first year of life.
- 50% of CAH parents brought up difficulty discussing genital surgery with their adolescent child.
- Relationship between child and parents was statistically different 50% in the late surgery group vs the control 71% and early surgical group 78%.
- Social integration during childhood between all groups was not statistically different.
- 90% of parents and 95% of CAH children reported a positive vision of their relationship with the medical world.
- 89.7% of patients and 100% of parents thought genitoplasty should be performed in first year of life.
 - Controls thought surgery should be later.
- Conclusions:
 - “Resolving early on the adequacy of genital anatomy with the sex assigned is promoted by patients as well as parents.”
 - “The results of this study promote, in our opinion, the early surgical management of DSD in CAH-DSD genotypic females.”

Bradley SJ, Oliver GD, Chernick AB, Zucker KJ. Experiment of nurture: ablatio penis at 2 months, sex reassignment at 7 months, and a psychosexual follow-up in young adulthood. Pediatrics 1998;102(1): e9.

Cassia Amaral R., Inacio M, Brito VN, et al. Quality of life in a large cohort of adult Brazilian patients with 46,XX and 46,XY disorders of sex development from a single tertiary centre. Clin Endocrinol (Oxf). 2015;82(2):274-279. doi: 10.1111/cen.12572.

Dangle PP, Lee A, Chaudhry R, Schneck FX. Surgical Complications Following Early Genitourinary Reconstructive Surgery for Congenital Adrenal Hyperplasia-Interim Analysis at 6 Years. Urology 2017;101:111-115. doi: 10.1016/j.urology.2016.11.027.

- Retrospective review identifying 26 patients from April 2003 to April 2015 with CAH who underwent genitourinary reconstructive surgeries.
- The average age at the time primary surgery was 17 ± 20 (5-87) months and the average length of follow-up was 72.56 ± 36.95 (4.5-142) months.
- The average length of the common urogenital sinus was 4.5 ± 1.9 (2.5-6.4) cm, and 15 out of 22 (68%) patients had high confluence.

- A total of 7 complications were observed in 7 (27%) patients, 2 required revision surgery.
- Authors note that, “there have been very limited reports of long-term outcomes of genitourinary reconstructive surgery with contemporary surgical approach. One important observational study in 2001 showed poor clinical outcomes of a cohort of adolescent girls who had undergone feminizing surgery in early childhood...authors acknowledge that these surgeries were performed prior to the era of new surgical approach, and since then there have been major changes in surgical techniques, sutures, and antibiotics.”
- This contemporary series suggests that genitourinary reconstructive surgery for CAH patients is technically feasible and safe at a young age, with a low complication rate.

Dayner JE, Lee PA, Houk CP. Medical treatment of intersex: parental perspectives. J Urol. 2004;172(4 Pt 2):1762-1765; discussion 1765.

- Questionnaire: 21 parents of 17 CAH patients at a single center to assess parental perception of education and initial medical management, extent of treatment of options, the role parents were allowed to participate in decision and feelings about disclosure of diagnosis to child.
- Children were 8mos-13yrs.
- Most parents were “completely or partially satisfied” with information provided to them in neonatal period concerning education of condition and treatment options.
- Uniformly all parents felt that the condition should be discussed with their children.
- “All parents disagreed with postponing genital surgery until children were old enough to consent.”
- All parents felt they were involved in the treatment decisions.
- Parents saw genital surgery as an integral part of their child’s care, they were not impacted by arguments made by some to defer or delay surgery and felt satisfied with their decision to undergo early genital surgery.

Dessens AB, Slijper FM, Drop SL Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia. Arch Sex Behav. 2005;34(4):389-397.

Fagerholm R, Santtila P, Miettinen PJ, Mattila A, Rintala R, Taskinen S. Sexual function and attitudes toward surgery after feminizing genitoplasty. J Urol. 2011;185(5):1900-1904. doi: 10.1016/j.juro.2010.12.099.

- Questionnaire of adult women who had undergone genital surgery in Finland to assess whether early surgical intervention for ambiguous genitalia impairs sexual function in adult woman.
- 45 pts. >15yo sent questionnaires: 24(53%) participated.
- 16 had prenatal androgen exposure (CAH; age 15.5yo – 36.7yo (median 25yo) and 8 had androgen sensitivity.
- 19 had undergone clitoral reduction (mean age of 3.8 years) and 21 had vaginal reconstruction mean age 4.5yrs (0.4-19.2).
- Most important:
 - Only two patients regretted the operation, one of which had a procedure that is no longer performed (clitoral resection without nerve preservation.) The other patient had creation of a sigmoid vaginoplasty and had distressful hospital experience.
 - None thought surgery was performed too early, while 17 thought it was done at the proper age.
 - 3 pts thought it was too late (age at surgery 9yrs, 14yrs, 17yrs).
 - In terms of sexual experience/function in comparison to adult control females, the index group started activity at a later age (19.2 vs 17.1)p=0.002. and engaged less frequently in sexual activity. Most importantly, sexual function was similar to that of controls.
 - “Early surgery is preferred by the patients.”

Gillam LH, Hewitt JK, Warne GL. Ethical principles for the management of infants with disorders of sex development. *Horm Res Paediatr.* 2010;74(6):412-418. doi: 10.1159/000316940.

Gonzalez R, Ludwikowski BM. Should CAH in Females Be Classified as DSD? *Front Pediatr.* 2016;4: 48. doi: 10.3389/fped.2016.00048.

Johannsen TH, Ripa CPL, Carlsen E, et al. Long-Term Gynecological Outcomes in Women with Congenital Adrenal Hyperplasia due to 21-Hydroxylase Deficiency. *Int J Pediatr Endocrinol.* 2010;2010:784297. doi:10.1155/2010/784297.

- Prospective study 33 CAH patients, 33 age matched controls.
- Looked at reproductive outcomes, genital appearance, function and sexuality, and were correlated to genotype and surgery.
- As expected, satisfaction with genital appearance was lower with more significant virilization.
- Three important points:
 - “A tendency for higher satisfaction with clitoral function was observed the younger the age at clitoral surgery.”
 - Type of surgery and timing of surgery is important for development of body image.
 - Significantly lower rating of clitoral appearance and function versus controls whether or not they had surgery.

Johnson EK, Rosoklija I, Finlayson C, et al. Attitudes towards "disorders of sex development" nomenclature among affected individuals. *J Pediatr Urol.* 2017;13(6):608 e601-608 e608. doi: 10.1016/j.jpuro.2017.03.035.

Kolesinska Z, Ahmed SF, Niedziela M, et al. Changes Over Time in Sex Assignment for Disorders of Sex Development. *Pediatrics.* 2014;134:e710–e715. doi: 10.1542/peds.2014-1088.

- Cases of disorders of sex development reported as partial androgen insensitivity syndrome (PAIS; n = 118), disorder of gonadal development (DGD; n = 232), and disorder of androgen synthesis (DAS; n = 104) were divided into those who were born before 1990, 1990–1999, and after 1999.
- Of the 118 cases in the pre-1990 cohort, 41 (35%) were raised as boys; of the 148 cases in the 1990–1999 cohort, 60 (41%) were raised as boys; and of the 188 cases in the post-1999 cohort, 128 (68%) were raised as boys.
- There are clear temporal trends in this practice pointing toward an increased likelihood of affected infants being raised as boys.

Lean WL, Deshpande A, Hutson J, Grover SR. Anatomical and Cosmetic Outcomes of Feminizing Genital Surgery for Intersex Disorders. *J. Pediatr Surg.* 2005;40(12):1856-1860.

- Retrospective cross-sectional study.
- Really is a review of John Hutson's patients.
- 30 pts treated at Royal Children's Hospital, Melbourne. 20 operated at RCH, 47% CAH
- Conclusions:
 - Planned one stage repair better cosmetic and overall outcomes than staged procedures.
 - Patients with initial surgery < 2 yo same outcomes as those operated after 2yo.
 - “Results do not support abandonment of childhood genital reconstruction.”

Lee PA., Nordenstrom A, Houk CP, et al. Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care. *Horm Res Paediatr.* 2016;85(3):158-180. doi: 10.1159/000442975.

Lin-Su K, Lekarev O, Poppas DP, Vogiatzi MG. Congenital adrenal hyperplasia patient perception of 'disorders of sex development' nomenclature. Int J Pediatr Endocrinol. 2015;2015(1):9. doi: 10.1186/s13633-015-0004-4.

Marei MM, Fares AE, Musa N, et al. Timing and Outcome Concerns regarding Feminizing Genitoplasty from the Perspective of Egyptian Families of Girls with Virilized External Genitalia. Horm Res Paediatr 2016;85:49-57. doi: 10.1159/000442200.

- Prospective analysis of parental attitudes regarding feminizing genitoplasty in 30 Egyptian girls who underwent surgery at a mean age of 22 months with a follow-up period ranging from 9-54 months.
- All of the parents stated that they believe that their girls would have had a significant psychological disturbance without surgery. Over half (70%) felt the surgery was performed at a suitable time and the rest (30%) felt it should have been performed earlier.
- The majority (93%) of families reported that the communications they received regarding their child's care were satisfactory.
- Egyptian parents wish the surgery to be performed at the earliest possible age due to a combination of intrafamilial pressures and beliefs, and to avoid stigmatization of their girls within their schools and society.

Meyer-Bahlburg HF. Intersex Care Development: Current Priorities. LGBT Health. 2017;4(2):77-80. doi: 10.1089/lgbt.2017.0021.

Meyer-Bahlburg HF. Introduction to the Special Section on Culture and Variants of Sex/Gender: Bias and Stigma. Arch Sex Behav. 2017;46:337–339. doi: 10.1007/s10508-016-0871-7.

- Historically, societies adhered to a binary gender system in alignment with the reproductive need for binary gender. As a result, those deviating from the binary construct in body, behavior, and/or identity have been accorded a special status, usually of inferior rank and associated with varying degrees of social stigma. The adherence to the binary system of gender are codified in the traditional religious systems and their rules of conduct.
- In the current world, the waning reliance on muscle power and importance of reproduction for survival has pared the traditional division of labor between the genders and, therewith, the traditional arguments for a binary gender system. Consequently, full human rights are increasingly demanded by, and gradually accorded to, both genders and, more slowly, to those not fitting the traditional gender categories.
- Variations in the rigidity/flexibility of the binary sex system and in gender bias between countries and subculture, including parental response to newborn genital ambiguity, are associated with major differences in gender socialization in childhood.
- Professionals conducting research or providing medical, mental-health, and social services to those with somatic intersexuality and to their parents and families, must gain familiarity with the diverse cultural and subcultural contexts affecting gender development and gender-related decision-making.
- Clinicians and researchers should be aware of religious diversity and avoid drawing stereotypic conclusions about a given religious gender ideology. Respectful inquiry of the role of religion in a given family is necessary, and the results taken into careful consideration for gender-related joint decision-making.
- Clinicians need to take into account the widespread potential of gender-related stigma in developing comprehensive, culturally competent clinical management policies.

Meyer-Bahlburg HF, Migeon CJ, Berkovitz GD, Gearhart JP, Dolezal C, Wisniewski AB. Attitudes of adult 46, XY intersex persons to clinical management policies. J Urol. 2004;171(4):1615-1619; discussion 1619.

- 72 English speaking patients with 46,XY, including 32 men and 40 women 18 to 60 years old,

completed the questionnaire.

- “The majority of respondents stated that they were mainly satisfied with being the assigned gender, did not have a time in life when they felt unsure about gender, did not agree to a third gender policy, did not think that the genitals looked unusual (although the majority of men rated their penis as too small), were somewhat or mainly satisfied with sexual functioning, did not agree that corrective genital surgery should be postponed to adulthood and stated that their genital surgeries should have been performed before adulthood, although there were some significant and important differences among subgroups.”

Meyer-Bahlburg HF, Reyes-Portillo JA, Khuri J, Ehrhardt AA, New MI. Syndrome-Related Stigma in the General Social Environment as Reported by Women with Classical Congenital Adrenal Hyperplasia. Arch Sex Behav. 2017;46(2):341-351. doi: 10.1007/s10508-016-0862-8.

- To assess the presence of stigma associated with women with somatic intersexuality, a report was generated based on in depth retrospective interviews with 124 adults with Congenital Adrenal Hyperplasia. The purpose of the report was (1) to document the existence of intersex-related stigma (Goffman’s “undesired differentness”) and to highlight its emotional impact, (2) to identify plausibly contributing factors, and (3) to make examples of stigma experiences readily available for use in the training of professional staff who care for such patients.
- Close to 2/3rd of women reported stigma.
 - Stigma conveyed by parents.
 - Occurred when bathing with other girls as a child.
 - Parental reaction conferred this was a condition that is not to be openly discussed.
 - Stigma conveyed by peers.
- Concerns about taking medicine.
 - Concerns about aberrant hair growth and teasing.
 - Stigma enacted by others at adulthood.
- Atypical bodies features (deep voice, hair distribution).
 - Being mistaken as a man.
 - Undue stress created by Media was a major issue for some women. They never thought themselves as neither man nor woman but the media portrayed it this way.
 - Stigma was often anticipated to be felt by girls with CAH from others that knew they were different. It impacted their ability to form close friendships.
 - Anticipated stigma coping as Adults.
 - Would engage in techniques or avoid activities to avoid situations that created stress with breast development or hair distribution.
 - Stigma internalization as adults was not uncommon.
 - The appearance of masculine features was particularly disturbing or need to address (such as shaving back hair).
 - In summary, anticipating, experiencing and internalizing stigma associated with CAH was quite common.

Meyer-Bahlburg HFL, Khuri J, Reyes-Portillo J, Ehrhardt AA, New MI. Stigma Associated with Classical Congenital Adrenal Hyperplasia in Women's Sexual Lives. Arch Sex Behav. 2017. doi: 10.1007/s10508-017-1003.

Meyer-Bahlburg HFL, Khuri J, Reyes-Portillo J, New MI. Stigma in Medical Settings As Reported Retrospectively by Women With Congenital Adrenal Hyperplasia (CAH) for Their Childhood and Adolescence. J Pediatr Psychol. 2017;42(5):496-503. doi: 10.1093/jpepsy/jsw034.

- The natural history of having atypical genitalia in intersex individuals that is not surgically corrected is not well described although preliminary evidence would suggest that there are

significant psychosocial consequences in such individuals.

- In females with CAH, the most common form of intersex, there is significant stigma related to their medical condition. Most individuals describe experiencing, anticipating, and/or internalizing stigma related to their medical condition. The emotional impact can be intense, and the psychosocial implications pervasive.
- There is a high incidence of internalization of this stigma within the context of their romantic / sexual lives. The presence of stigma is especially true in cases where there are internal and/or features that are not completely consistent with a female phenotype. This conclusion may also apply to other syndromes of intersexuality as well.

Mouriquand PD, Gorduza DB, Gay CL, et al. Surgery in disorders of sex development (DSD) with a gender issue: If (why), when, and how? J Pediatr Urol. 2016;12(3):139-149. doi: 10.1016/j.jpuro.2016.04.001.

- Late surgery can have a better accompanying process, allowing the individual to participate in the decision process. It may also reduce the risk of a second procedure to enlarge the vaginal introitus as the patient complies with post-operative vaginal dilatations if necessary.
- Pubertal or post-pubertal surgery has a much greater risk of morbidity compared with surgery earlier in childhood. Blood loss and infection are more common in adult genital surgery. Very few surgeons have experience with late feminization.
- Several cohorts of adult patients who underwent a feminization procedure at various ages have recently been interviewed in different French hospitals and all claimed that early surgery is highly preferable to late surgery [Binet et al, Carval et al (in French)].
- When asked retrospectively when feminizing surgery should occur, more women with CAH responded that surgery should occur early compared with later in development [Wisniewski et al, Fagerholm et al].
- Women with DSD because of CAH who received genitoplasty reported higher satisfaction with their care than those who did not receive early genital surgery [Thyen et al].
- Girls who received early genital surgery have a good or satisfactory cosmetic outcome, as assessed by healthcare providers, good quality of life, and a low incidence of gender dysphoria as reported by their parents [Crawford et al, Cassia Amaral et al].

Nordenskjold AG, Holmdahl G, Frisen L, et al. Type of mutation and surgical procedure affect long-term quality of life for women with congenital adrenal hyperplasia. J Clin Endocrinol Metab. 2007;93(2):380-386. doi: 0.1210/jc.2007-0556.

- In a case-control follow up study in Sweden, 62 women aged 18-63 and 62 age-matched controls were recruited for review of prior medical records, examination and completion of a questionnaire regarding social life, fertility, sexuality, function of the clitoris and vagina, satisfaction with results and experience of health care as children.
- Clitoroplasty and/or vaginoplasty were performed in 49 girls and of these 16 had only one procedure, 10 of these at puberty. The majority had surgery between age 6 months and 9 years and 20% reported that they were not satisfied with the surgery. Some of the procedures performed (clitoral amputation and burying) are not routinely performed currently.
- Clitoral sensitivity and orgasm capability may be decreased by clitoral amputation or recession but the results are variable but is intact in the majority of operated patients.
- A total of 37.5% of patients need reoperative vaginal surgery and 60% considered the size of their clitoris to be normal.
- The outcome is dependent upon the severity of the initial condition.
- Many aspects of quality of life are affected by CAH, such as sexual debut, fertility, partnership, and sexual relationships. It should be taken into account, when providing psychosocial support for

patients, that the incidence of homosexuality and bisexuality is significantly higher than in controls.

- The experience of medical checkups was regarded as “mostly positive” and most CAH women who responded preferred early surgery (70%).
- The authors argue that the medical, surgical, and psychological treatment of CAH patient should be centralized to specialized teams.

Sudai M. Changing ethical and legal norms in the management of differences of sex development. Lancet Diabetes Endocrinol. 2017;5(10):764-766. doi: 10.1016/S2213-8587(17)30043-8.

Szymanski KM, Whittam B, Kaefer M, et al. Parental decisional regret and views about optimal timing of female genital restoration surgery in congenital adrenal hyperplasia. J Pediatr Urol. 2017. doi: 10.1016/j.jpuro.2017.11.012.

- Cross-sectional online study.
- 39 parents questioned median 4.4 years after Child had Feminizing Genital Restoration Surgery.
- Decisional Regret scores 0 to 100 (higher means more regret).
- Median DR score after FGRS was 0, mean was 5.
- Most parents reported no regret after surgery and when they did it was generally mild.
 - No one reported strong or very strong regret.
- In total 20.5 % had some mild or moderate decisional regret after surgery but if you look at other reported scores, FGRS DR scores were much less:
 - Adenotonsillectomy: DR in 41-45%
 - Hypospadias: DR in 50-92%
 - Ped. Cancer treatment: DR in 61-72%
- Daughters of parents who wanted earlier surgery had FGRS at median 24 mos, those who wanted it at the same time had surgery at median 8mos.
- No parent preferred delaying surgery even in those with some decisional regret.
- 18% preferred earlier surgery.

Thyen U, Lux A, Jürgensen M, Hiort O, Köhler B. Utilization of Health Care Services and Satisfaction with Care in Adults Affected by Disorders of Sex Development (DSD). J Gen Intern Med. 2014;29(Suppl 3):752-759. doi:10.1007/s11606-014-2917-7.

Wang LC, Poppas DP. Surgical outcomes and complications of reconstructive surgery in the female congenital adrenal hyperplasia patient: What every endocrinologist should know. J Steroid Biochem Mol Biol. 2017;165(Pt A):137-144. doi: 10.1016/j.jsbmb.2016.03.021.

- Surgical techniques for genital feminization in female CAH patients have evolved significantly over time as more has been learned about clitoral neurovascular anatomy, vaginoplasty outcomes, improved surgical techniques and patient satisfaction with functional and cosmetic outcomes.
- After Baskin et al. reported on the detailed neurovascular anatomy of the clitoris in 1999, previous clitoroplasty techniques which resulted in the complete or partial loss of the nerves associated with the clitoris, were abandoned.
- Today, reduction clitoroplasty, where a portion of the erectile bodies is excised, with complete or partial glans sparing, is predominantly utilized for optimal cosmetic effect with minimal consequences to clitoral function.
 - Dessens et al. found that the large majority (94.8%) of CAH 46, XX patients assigned female gender identified as female. However, of the 5.2% of CAH patients who experienced gender dysphoria, 30% wanted to change gender, which exceeds the rate in the general population of chromosomal females.
 - Twenty-six (87%) of the 30 CAH women reported having genital surgery and 65.4% were very satisfied with surgical treatment, 60.0% were very satisfied with genital

appearance, and 60.9% were very satisfied with genital function (Zucker et al 2004).
Women with simple virilizing CAH and those assigned female at birth were more likely (p=0.10) than patients with salt-wasting CAH and those with delayed assignment or male assignment to report higher levels of sexual arousability.

Wisniewski AB, Migeon CJ, Malouf MA, Gearhart JP. Psychosexual outcome in women affected by congenital adrenal hyperplasia due to 21-hydroxylase deficiency. J Urol. 2004;171 (6 Pt 1):2497-2501.

- Confidential Questionnaire Study.
- 134 women with CAH seen, 73 not eligible for study.
 - 61 questionnaires sent, 41 women with CAH studied.
 - Had 30 controls.
- Adult women with salt-losing CAH are more likely to question their female gender, report sexual concerns and worse genital function and are less likely to have sexual relations with a partner than those with simple virilizing CAH.
- Overall, women with CAH were moderately satisfied with the cosmetic appearance of the genitalia. Women with the salt-losing form were judged to have a worse cosmetic outcome of genital reconstruction than women with simple virilizing form.
- The most common response concerning the optimal timing for genital reconstruction was during infancy and early childhood and only 5% advocated for surgery in adulthood.
- “Women in both salt wasting and simple virilizing most frequently reported that infancy and early childhood were the best time for genital reconstructive surgery.”
 - (31% of SW and 18% of SV did not answer the question about timing.)

Yankovic F, Cherian A, Steven L, Mathur A, Cuckow P. Current practice in feminizing surgery for congenital adrenal hyperplasia; a specialist survey. J Pediatr Urol. 2013;9(6 Pt B):1103–1107. doi: 10.1016/j.jpuro.2013.03.013.

- Specialists surveyed at IVth World Congress of the International Society of Hypospadias and DSD.
- 161 delegates and 61 responded to survey (30 % Ped. Surgeons, 30% Ped. Urologists).
- Delegates were from around the world.
- Early surgery before age 2 years preferred by 78%.
- Most recommended doing clitoroplasty, labioplasty and vaginoplasty in single stage.

Zhang H, Pan J, Ji H, et al. Long-Term Evaluation of Patients Undergoing Genitoplasty due to Disorders of Sex Development: Results from a 14-Year Follow-Up. Scientific World J. 2013; 2013: 298015. doi: 10.1155/2013/298015262.

- 262 patients (96 children, 133 adolescents, and 33 adults) with mixed diagnoses cohorted into 6 groups based on karyotype (XY, XX), androgen effects (partial, none), gender assignment (male, female).
- Older cohort (mean age at diagnosis 14.3 ± 2.8 yrs (2–38 yrs)) followed every 6 mos.
- Sex assignment according to patients’ considerations, psychological gender, dominant gonad, and external genitalia development. The urological surgeon, endocrinologist, and pediatric psychiatrist provided important advice for sex assignment. However, the final decision should be made by the DSD patients and/or their relatives.
- Majority of women (93%) and men (62%) were satisfied with the outcome.
- Majority of women (83%) and men (54%) had favorable psychosocial adjustment.
- Female sex assignment less likely to have secondary surgery (3% vs 21%).

APPENDIX B

Example Paragraphs: More Thorough Review of Outcomes Data

Note: the following section is a revision of the Report, page 2, starting at line 35.

Since 2006, a number of published studies have helped to clarify attitudes and outcomes in the DSD/intersex population, although limitations include the rarity of DSD/intersex, the heterogeneity of the associated conditions and their treatment, and the difficulties inherent in long-term follow-up. For example, in a systematic review of follow-up of psychological outcomes of intervention for patients with DSD published in 2015, Brazilian researchers found a lack of prospective long-term evaluations of psychological outcomes of sex assignment surgery [13]. They noted concerns about the quality of published studies, citing variable sample size, inconsistent methodologies, and poorly defined outcome measures. However, most modern data demonstrate successful though variable, but often acceptable post-surgical outcomes in DSD/intersex patients. Satisfactory initial results and low complication rates were reported (Dangle et al. 2017, Wang and Poppas 2017) using surgical techniques that evolved with new (Baskin et al. 1999), detailed knowledge of clitoral neurovascular anatomy. In one of the largest long-term studies of CAH, clitoral sensitivity was most commonly impaired in women who underwent older types of surgeries that are currently considered suboptimal. Even so, there were no significant differences in orgasmic function among controls, operated, and unoperated patients (Nordenskjold et al. 2008). The severity of disease has been associated with worse outcomes (Wisniewski et al. 2004, Nordenskjold et al. 2008, Johannsen et al. 2010, Wang and Poppas 2017) and suboptimal sexual function occurs with equal frequency in operated and non-operated cases (Nordenskjold et al. 2008). A trend towards higher satisfaction with clitoral function in individuals undergoing surgery at a younger age has been reported (Johannsen et al. 2010). In mixed DSD/intersex series, quality of life scores were inversely correlated with age at surgery (Cassia Amaral et al. 2015), and 83% of 94 adults reported a “good” or “average” level of satisfaction with regard to sexual function (Thyen et al. 2014). Reporting multiple measures of sexual function, many studies suggest that outcomes for individuals who underwent genital surgery in childhood are similar to controls (Meyer-Bahlburg et al. 2004, Fagerholm et al. 2011, Binet et al. 2016).

Current studies of psychological well-being point to satisfaction with early repair. Particularly in CAH, the most common form of intersex, the majority of affected individuals remained satisfied with female gender, comprising 98.4% of a large series of 250 affected individuals (Dessens et al. 2005). Finally, a majority (69-100%) of adult DSD/intersex individuals and their families reported that early surgery is desirable, and some individuals in these series noted that surgery was performed too late (Dayner et al. 2004, Meyer-Bahlburg et al. 2004, Wisniewski et al. 2004, Nordenskjold et al. 2008, Fagerholm et al. 2011, Binet et al. 2016, Marei, Fares et al. 2016, Szymanski et al. 2017). Moreover, in extensive studies of individuals with CAH, Meyer-Bahlburg and colleagues reported that stigma, defined as “undesired differentness”, is common among adult women with CAH and remains a potential risk associated with delayed intervention (Meyer-Bahlburg et al. 2017).

Prospective studies are ideal but not yet available, and controversies remain. However, increasing evidence suggests that genital surgery in childhood typically provides good outcomes. There is limited data regarding delaying surgery until later in life, but evidence exists that early surgery may be preferred and psychosocial distress may be a significant risk for individuals in whom surgery is delayed.

**Testimony for the Council on Ethical and Judicial Affairs
of the American Medical Association**

Ethical and scientific issues in early childhood genital surgery for intersex/differences of sex development (DSD): the case of feminizing genitoplasty in 46, XX congenital adrenal hyperplasia

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Introduction

As Coordinator of Medical and Research Affairs for the Androgen Insensitivity Syndrome-Differences of Sex Development Support Group (AIS-DSD SG) and Chair of Medical and Research Policy Committee for interACT Advocates for Intersex Youth, I submit this written testimony in support of Michigan resolution 013, “Opposing Surgical Sex Assignment of Infants with Differences of Sex Development,” introduced to the Reference Committee on Amendments to Constitution and Bylaws.

I am a physician member of AMA and the mother of 2 intersex women with the DSD complete androgen insensitivity syndrome (CAIS). My older daughter, Katharine Dalke MD, is a psychiatrist, AMA member, and fellow intersex advocate. My clinical practice since 1990 is in diagnostic radiology as a breast imaging radiologist. For the last 18 years, I have worked extensively in support and advocacy for families and individuals affected by intersex/DSD. My service to the intersex/DSD community includes participation on the boards of the Intersex Society of North America (ISNA), the AIS-DSD SG, Accord Alliance, and interACT Advocates for Intersex Youth (abbreviated as interACT from here on); I am a founding member of the latter 2 groups. My educational efforts include coordinating the AIS-DSD SG continuing medical education program since 2011, as well as co-authorship of book chapters and peer-reviewed articles, including the 2016 Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care. In addition to presenting at meetings of the International DSD Symposium (I-DSD); Societies for Pediatric Urology (SPU); World Professional Association for Transgender Health (WPATH); GLMA Health Professionals Advancing LGBT Equity; North American Society for Pediatric and Adolescent Gynecology (NASPAG); and Philadelphia Trans Wellness Conference, I’ve been a consultant/advisor on 2 NIH-funded research projects: Short Term Outcomes of Interventions for Reproductive Dysfunction (1R01HD074579-01A1) and Disorders of Sex Development: Platform for Basic and Translational Research (1R01HD068138-01A1). My CV is appended to this testimony as Appendix A.

Why is the practice of early genital surgery a matter for the Council for Ethical and Judicial Review?

Differences or disorders of sex development (DSD), also known as intersex conditions (these terms will be used interchangeably), are unexpected patterns of sex traits, including chromosomes, gonads, or genitalia, that may challenge traditional binary concepts of sex and gender. Some conditions are associated with significant gender uncertainty. Unless associated with urinary obstruction or abdominal wall defect, these traits pose no intrinsic threat to physical health. This testimony is specifically focused on elective cosmetic surgery and does not call for what proponents in the Societies for Pediatric Urology (SPU) characterize as “a moratorium on all surgery...[and] extending the moratorium to other genital surgery not even related to this area.” [1] While sex and gender fluidity are well-accepted by many clinicians, medicalized portrayals of the

variation of sex traits occurring in DSD/intersex as inherently “disordered” and stigmatizing perpetuate a long-standing paradigm focused on treatments aimed at eradicating physical differences, including normalizing surgery to create dimorphic-looking genitals. Such surgery is performed on children with healthy genitals to avert future psychosocial issues presumed to arise from intact genital difference, even though a causal relationship has never been proved. When genital surgery is performed on children who are too young to express their gender, sexuality, or what they want their bodies to look like, it is a form of conversion therapy- an unconsented, irreversible medical intervention to “treat” hypothetical adult psychopathology. When surgery aligns genital appearance with a gender that is discordant with a child’s future gender identity, it is also a form of involuntary sex reassignment. Our AMA has strongly repudiated conversion or reparative therapy for LGBT people (policy H-160.991), and my testimony is intended to demonstrate why the Committee for Ethical and Judicial Affairs (CEJA) should endorse this resolution recommending that the analogous practice of early surgery on intersex children be deferred until children can participate meaningfully in decision-making.

Feminizing genitoplasty: who, what, why, when, and how much does it cost?

In current debates in our AMA and in the California legislature (regarding the recently-approved CA SCR-110) about deferring genital surgery until children can consent for themselves, surgery proponents focus on early feminizing genitoplasty (FG) in 46,XX classical congenital adrenal hyperplasia (CAH), the most common operation for “correcting” genital difference. To address their contentions, and because the majority of studies on genital surgery address feminizing genitoplasty (FG) in 46,XX classical congenital adrenal hyperplasia (CAH), I will also focus on it in this testimony. In CAH, reductions in fetal 21-hydroxylase enzyme activity cause diversion of cortisol +/- aldosterone steroid precursors into pathways that produce of unusually large quantities of androgens, resulting in varying degrees of genital difference. In salt-wasting (SW) CAH, genetic alteration of 21-hydroxylase enzyme causes life-threatening decreases in both cortisol and aldosterone that require medical management; in a milder form of CAH, “simple virilizing” (SV), only cortisol is diminished. Genital difference ranges from a clitoris that is slightly larger than usual to development of a penis, scrotum, and urogenital sinus with a single external opening from the vagina and bladder. The continuum of genital atypia is described by the Prader scale of 1-5, with higher numbers indicating less female-typical genitals. This interactive video demonstrates the spectrum of genital differences: (<https://pie.med.utoronto.ca/htbw/module.html?module=sex-development>) The usual situation in which FG would be considered is moderate-to-severe genital atypia, as defined by a Prader 3-5. [2]

FG consists of procedures to change the appearance of the external genitals to look more female, including clitoroplasty and perineal procedures, as well as separation of the urethra and vagina (vaginoplasty). Ideally, these procedures would “spare” neurovascular structures. Justifications for FG in CAH, usually performed between the 2nd and 6th month, include creation of “normal” looking feminine external genitalia; allowing “normal” penetrative sexual intercourse (as a female); and facilitating future reproduction (as a female). [3] Purported psychosocial benefits include promotion of parental bonding and prevention of assumed future psychosocial issues, which have never been proved. [4, 5]

The birth of a child with CAH can be overwhelming for parents. The presence of genital difference in a child with a life-threatening medical illness understandably creates an atmosphere of distress. Clinicians as well as parents are vulnerable to an urgent desire to “fix” something as soon as possible. Families rely on physicians to provide them with evidence-based care, but authoritative guidelines from organizations such as our AMA are lacking. With CAH being both rare and having implications for gender and sexuality, there are fundamental disagreements among stakeholders over research methods, relevant outcomes, and what should even be considered “evidence.” Conflicting values and beliefs are manifest in ethical controversies including who has the right to choose when children’s fundamental human rights to bodily autonomy are at stake, and what constitutes informed consent when parents are distraught and vulnerable. Unfortunately, high-visibility clashes over early surgery obscure the overarching goal of advocates for children with DSD/intersex traits, which is to implement effective psychosocial interventions as primary treatment for families experiencing psychosocial issues such as distress at the birth of a child with atypical sex traits. [6]

Ongoing disputes over surgery divert attention and resources from development of and reimbursement for such interventions, perpetuating lack of access to appropriate providers for many families. [6]

There is no study of genital surgery showing its noninferiority to psychosocial intervention. Nonetheless, as standard practice in many clinics, FG is usually performed by age 2, before children can assent or consent. [7] Providing a view of the current state and cost of surgical care in the US, recent review of a national billing database from 2004-2014 shows that 544 (12%) of 4617 children assigned female with 46 XX, CAH at 43 hospitals underwent initial genital surgery at median age 10 months (all under 19 months). [8] Three high volume centers (> 30 procedures over 10 years) accounted for 30% of the surgery. Of the 1229 FG procedures performed, 92% of children underwent a vaginal procedure, 48% had a clitoral procedure, and 85% had a non-clitoral perineal procedure (involving the perineal musculature and soft tissues in conditions with atypical perineal anatomy). Between 2004 and 2014, the rate of clitoral surgery increased from about 50% to about 70%. During the initial stay, 4% of children suffered perioperative surgical complications, and 2% required reoperation. Postoperatively, 14% were readmitted within 30 days, with the most common diagnoses being CAH (21.3%), surgical complication or hemorrhage (16.0%), infectious enteritis or gastroenteritis (10.7%), and urinary tract infection (5.3%). The mean cost of care for initial surgery was \$12,258, with \$20,000 in operating room expenses; readmission costs were not specified.

The surgical paradigm has its roots in the 1950's "optimal gender" theory of psychologist John Money: in cases where genitals do not clearly indicate natal sex, proper nurture and surgical creation of binary-appearing genitals capable of heteronormative penetrative intercourse can trump biological uncertainty to prevent future psychological problems.[9] With the right socialization, a child's gender would reflect the appearance of his or her genitals. Given the role of surgery in cosmetic alteration, technological considerations also influenced gender assignment. For example, despite the presence of normal testes, a child with a small phallus considered "inadequate" for vaginal penetration was castrated and assigned female, because, as some quipped, "it's easier to dig a hole than build a pole."

Although the optimal gender theory was later discredited, surgery retains a prominent role in intersex treatment. The purpose of normalizing genital surgery is to avert projected consequences of uncorrected genital difference: to "restore functional genital anatomy to allow future penetrative intercourse (as a male or a female); facilitate future reproduction (as a male or a female) when possible; ... foster development of 'individual' and 'social identities;' avoid stigmatization related to atypical anatomy; [and] respond to the parents' desire to bring up a child in the best possible conditions." [3] Conflict is inevitable because these goals, which strongly prioritize binary gender and heteronormative sexuality, are not shared by all stakeholders.

Known risks of FG

Early FG for medically-vulnerable children with CCAH exposes them to many risks, including perioperative adrenal crisis, for which preventive steroid "stress dosing" is given to supplement chronic steroid replacement. The 14% 30-day readmission rate discussed may reflect significant stress related to surgery, given that in general about a third of patients with SWCAH are hospitalized during childhood, mostly for infectious conditions during the first 2 years of life. [8, 10] Because steroid excess in CCAH may impair wound healing, a 4-week period of postoperative immobilization is recommended, with placement of a restrictive dressing preventing children from opening their legs. [7] Risks and complications of FG include the harms of anesthesia, postoperative pain, vascular injury, bleeding, hemorrhage, hematoma, wound infection, glans necrosis, flap necrosis and dehiscence, nerve damage, femoral nerve neuropathy, permanent reinforcement of misassigned gender, necessity of multiple procedures, clitoral re-enlargement, vaginal stenosis, hair growth in the vagina, dysuria, UTI, urinary retention, urinary incontinence, sexual dysfunction and loss of sexual sensation [7, 11-14]. Vaginal stenosis requiring revision surgery is a common complication of vaginoplasty. In a review of procedures performed after 1985, the rate of vaginal stenosis was 6–57% and the rate of revision vaginoplasty was 3–36%. [7] Although nerve-sparing clitoroplasty may leave some with normal sensation and orgasmic potential, in long-term follow up, only one out of every

three women who have had such procedures demonstrate sensitivity to temperature and vibration that is similar to unaffected women. [15]

The risk of exposing medically-fragile children to anesthesia for elective procedures deserves special ethical consideration. In 2017, the US Food and Drug Administration (FDA) announced that pediatric anesthesia may negatively affect brain development, and issued its strongest possible warning. [16] The potential consequences of avoidable anesthetic risk for children with SWCAH may be inferred from a large 2018 population-based study of anesthesia risks with results that are generalizable because of the number of children studied. Schneuer et al, in *The Impact of General Anesthesia on Child Development and School Performance: a Population-based Study*, correlate school data with anesthetic exposure in children from Australia's state of New South Wales (NSW). [17] For children exposed to general anesthesia (excluding those with major congenital and neurocognitive conditions), internationally-validated developmental assessment measures for 82,156 children were available, and nationally-validated school test results for reading and numeracy (ability to work with numbers) for 153,025 children. 16% of all children were exposed to anesthesia. To assess development at school entry, children in NSW are given the AvEDI, a developmental test that assesses social competence as well as 5 domains: physical health and well-being, emotional maturity, communication skills and general knowledge, language, and cognitive skills (numeracy and literacy). Scores in the lowest 10% in 2 or more domains indicate high developmental risk. Children undergo reading and numeracy testing in Grade 3. [17] Schneuer et al found that a single hospitalization with anesthesia exposure is associated with poorer numeracy. Children with more than one general anesthetic exposure are at risk of poor developmental outcomes before starting school, and with substandard reading and numeracy scores on school testing. [17]

In children with CCAH, for whom repeat surgery in early childhood is not uncommon, these findings may have particular relevance. A prospective US study of elective early FG performed by expert surgeons in multidisciplinary care settings found that in the first year alone, 7% of children under expert care underwent repeat surgery, placing them at risk of poor developmental outcomes and low school performance. [18] This risk adds to the known cognitive disadvantage conferred by CCAH treated with current glucocorticoid regimens, confirmed by brain imaging and cognitive assessment in adults showing widespread reductions in white matter structural integrity, and decreased working memory, processing speed, and digit span and matrix reasoning scores relative to controls of similar education and intelligence.[19] Parents interviewed for a recent report by Human Rights Watch (HRW) and interACT Advocates for Intersex Youth (interACT) were not informed of potential neurotoxic effects of anesthesia.[20] Disclosure of anesthetic risk for procedures that are completely elective and unlikely to affect short-term health, such as early FG, deserve serious discussion and consideration of deferring those procedures, especially in the setting of pre-existing cognitive risk. [21] A consent procedure for pediatric anesthesia developed by Texas Children's Hospital, which includes reviewing "the possibility that the procedure could be delayed until after 3 years of age," might be adapted for this use. [22]

Limitations of current research in intersex/DSD

Most evidence that is claimed to support the standard of early surgery comes from research that focuses primarily on techniques, cosmetic outcomes, and patient "satisfaction," with methods devised only by clinicians, some of whom have circumvented advocates' efforts to engage in community-based participatory research (see Appendix B). [23] NIH classifies DSD/intersex as a sex and gender minority, a health disparity population deserving special attention, but its status as a rare condition is often neglected in research design. [24] The extant literature mostly fails to address patient-centered outcome measures (PCOM) of importance to families and patients, such as developing viable and effective psychosocial and educational alternatives. [5, 25] A recent position paper by the International Rare Diseases Research Consortium (IRDiRC) provides a road map for collaborative development of PCOM on the premise that patients are the experts on the outcomes

that resonate with their daily experience of a condition, across a continuum of manifestations, and their preferences, expectations and values.[26] For example, for many years, studies on Duchenne muscular dystrophy (DMD) have focused on ability to walk. However, when boys and young men with DMD were interviewed, their narratives revealed that what mattered to them was retention of upper body function: to

be able to use a computer keyboard, brush their teeth, and pour a drink. PCOMs should be developed in collaboration with patient groups but too often foundational patient qualitative works are ignored in intersex/DSD research. A traditional psychometric data-driven approach to PCOM is inherently inappropriate in rare conditions because, of limited available data to drive the decisions, a common complaint about intersex/DSD research. Because there is no inherent constraint on the intelligence we could use in this research, IRDiRDC describes the use of mixed methods psychometric research as the best fit for rare conditions, citing its ability to synthesize qualitative and quantitative research methods to most efficiently use data from small samples [27], and to determine content validity by optimizing clinical relevance, improving understanding of study constructs, and avoiding potential early measurement issues. Processes that implement such PCOM research for intersex/DSD is rare.

Supporters of early FG agree with advocates of deferral that there are currently insufficient data to support assertions that adult women are satisfied with the results of early surgery.[28] Since there is no research directly comparing outcomes of early and late FG, we cannot know which is better, although some gynecologists who perform both primary FG and surgery to treat subsequent complications in older patients advocate for deferral. [2] [29] Unsupported assertions of superiority of early FG distract from the uncomfortable truth that pediatric specialists themselves prefer it because they are not trained to perform surgery in older, consenting individuals. Six-year follow up of successful single-stage adult genitoplasty with preservation of orgasm was reported by Tjalma in 2016; the operation preserving the erectile tissue of the corpora cavernosa in a previously-orgasmic woman with CCAH also eliminated the need for revision vaginoplasty because the woman was already sexually active.[30]

Prospective study of outcomes of modern neurovascular-sparing surgery in the “ideal” setting of multidisciplinary centers does not show the hoped-for reduction in complications: after just one year, 10% of FG procedures had serious complications. The short-term complication rate for proximal hypospadias surgery was 40%, consistent with statistics for complications of these procedures performed in other settings.[31, 32]

Although some centers provide anecdotal evidence of adult CCAH patients requesting primary or revision surgery, there are corresponding anecdotes of unoperated intersex adults who are grateful to have been spared infant surgery, such as 60-year-old Jim Costich, who posted on Facebook: “I did not have any genital surgery to make me look any different and... my love life, my social life, my gym life, even my life as a nudist has not been adversely affected!”

Human rights focus in advocacy for children with intersex/DSD

Follow up studies of FG that have mostly focused on surgical results, sexual function and psychosexual outcome show unsatisfactory long-term consequences in many cases, corroborating the complaints of adults subjected to surgery. [2, 15, 33] The paradigm of early genital surgery has been publically challenged by intersex adults and community advocates since formation of the Intersex Society of North America (ISNA) in 1993. [9] Over the years, vocal advocacy efforts have culminated in increasing calls from governmental and human rights organizations to recognize intersex patients’ autonomy and end nonconsensual childhood genital surgery. [34] In 2015, the World Health Organization (WHO) published a report specifically examining childhood intersex genital surgery titled [Sexual Health, Human Rights and the Law](#), which calls for deferring surgery and allowing children to make their own decisions, and the United Nations condemned the practice of medically-unnecessary normalization of intersex children’s genitals, finding it a violation of their rights to physical integrity and to be free from torture. [35, 36] The same year, the European Union Agency for Fundamental Rights advised member states to avoid surgery, and Malta instituted a national moratorium. [37] In 2017, a US State Department press release declared, “At a young age, intersex persons routinely face forced medical surgeries without free or informed consent. These interventions jeopardize their physical integrity and ability to live freely,” and ACLU posted that “[i]t is plainly unethical, cruel, and unnecessary to perform surgeries on the genitals of children and infants because we are afraid that their bodies do not seem normal and out of an impulse to ‘assign’ a binary sex to a child before that child can articulate their gender.” [38, 39]

Physician leaders and organizations have expressed similar ideas. In 2016, our AMA Board of Trustees issued a report recognizing that “DSD communities and a growing number of health-care professionals have condemned. . . genital ‘normalizing,’ arguing that except in the rare cases in which DSD presents as life-threatening anomalies, genital modification should be postponed until the patient can meaningfully participate in decision making,” and recommending that our AMA support care that “(1) seeks to foster the well-being of the child and the adult he or she will become; (2) respects the rights of the patient to participate in decisions and, except when life-threatening circumstances require emergency intervention, defers medical or surgical intervention until the child is able to participate in decision making; and provides psychosocial support to promote patient and family well-being.”[40] In 2016, GLMA: Health Professionals Advancing LGBT Equality became the first medical association to officially recommend “delay of any surgical interventions and gender-related medical interventions for DSD that are not deemed medically necessary until the patient can provide informed consent/assent to these interventions.”[41] In 2017, three former U.S. Surgeons General wrote that “[c]osmetic genitoplasty should be deferred until children are old enough to voice their own view about whether to undergo the surgery. Those whose oath or conscience says ‘do no harm’ should heed the simple fact that, to date, research does not support the practice of cosmetic infant genitoplasty.”[42] The same year, Physicians for Human Rights advocated for “an end to all medically unnecessary surgical procedures on intersex children before they are able to give meaningful consent to such surgeries,” and the American Medical Student Association endorsed “the deferment of elective surgical interventions to standardize genitals as strictly male or female on intersex children until they reach a level of maturity at which they can participate in this life-altering decision and provide (or withhold) informed consent to such treatment,” adding, “[a]s future medical professionals, we chose this path in order to help others, not to do harm. If current practices are harmful, we should not perpetuate them through inertia. We can—and must—change medical education and practice to safeguard vulnerable patients.” [43] [44] In 2018 the American Academy of Family Physicians stated, “many intersex children are subjected to genitalia-altering surgeries in infancy and early childhood without their consent or assent. The surgery can lead to decreased sexual function and increased substance use disorders and suicide. Scientific evidence does not support the notion that variant genitalia confer a greater risk of psychosocial problems.”[45] Also in 2018, the Michigan Medical Society proposed a resolution recommending “[t]hat our American Medical Association oppose the assignment of gender binary sex to infants with differences in sex development through surgical intervention outside of the necessity of physical functioning for an infant and believes children should have meaningful input into any gender assignment surgery.” [46]

The issue of non-consensual early intersex surgery was raised in US consciousness in July 2017 when Human Rights Watch (HRW) and interACT released a highly-publicized landmark report, *“I Want to be Like Nature Made Me: Medically Unnecessary Surgeries on Intersex Children in the US,”* a high-profile investigation of current medical care and its scientific basis. [20] Unlike most research in this area, methods were developed in collaboration with the intersex community; the research design was reviewed by HRW’s children’s rights division, health and human rights program, LGBT rights program, women’s rights division, disability rights division, and legal department. Participants were recruited from support group networks and online networking groups for intersex people. Parents and adults expressing concern were also interviewed. In total, 32 adults, 23 parents, and 2 teens were interviewed. 218 formal outreach letters soliciting a wide range of views were sent to clinicians; although follow up letters were sent, 195 never responded. 21 clinicians were interviewed. The HRW/interACT report found that current surgical practices for intersex/DSD with “procedures that could be delayed until intersex children are old enough to decide whether they want them” lack evidence-based scientific justification, fail to provide adequate education to families considering surgery, and violate children’s rights to self-determination and bodily autonomy. [20]

On 02/27/18, in the wake of the HRW/interACT report, California Senator Scott Wiener, interACT, and Equality California introduced [California Resolution SCR-110](#) . Passed on 8/28/2018, it affirms that the legislature “considers intersex children a part of the fabric of our state’s diversity to be celebrated rather than an aberration to be corrected; ...[t]hat the [l]egislature recognizes that intersex children should be free to choose whether to undergo life-altering surgeries that irreversibly—and sometimes irreparably—cause harm; and ... [t]hat the [l]egislature calls upon stakeholders in the health professions to foster the well-being of children born with variations of sex characteristics, and the adults they will become, through the enactment of policies and procedures that ensure individualized, multidisciplinary care that respects the

rights of the patient to participate in decisions, defers medical or surgical intervention, as warranted, until the child is able to participate in decisionmaking, and provides support to promote patient and family well-being.” [47]

In July 2018, Lambda Legal published a policy guide for hospitals providing care to intersex people, [*Providing Ethical and Compassionate Health Care to Intersex Patients*](#). *Intersex-Affirming Hospital Policies*. [37] Model policies that hospitals can adapt for their own use are offered on topics including sex characteristics and intersex status nondiscrimination policy; patients’ bill of rights; medical treatment of intersex youth; and protocols for interaction with intersex patients and their families.

Ethical issues and consent

Who has the right to choose?

The ethics of FG are subject to fierce ongoing debate, and leading experts in the field condemn early FG. [9, 48, 49] NIH founded an Office of Sex and Gender Minority Research in 2015 and convened a workshop on DSD research. The ethicist NIH included in that workshop concluded that “[b]ecause children born with DSD have a right to an open future, and because the openness of their future is clearly enhanced by delaying cosmetic genitoplasty until they themselves can participate meaningfully in decision-making, early genitoplasty is ethically supportable only when medically indicated (e. g., when the child is unable to urinate without surgical intervention).” [49] [24] Proponents of early FG cite 2010 articles by Wiesemann et al [50] and Gillam et al [51] as supportive of the practice. Advocates of deferring surgery agree on basic ethical principles of treatment described by Wiesemann et al: fostering the wellbeing of the child and future adult; upholding the rights of children and adolescents to self-determination; and respecting family relationships.[50] Difficulties in actual management arise because these principles often conflict, particularly with respect to the value assigned to parental authority vs. children’s rights to autonomy. Wiesemann et al articulate this conflict in recommendations that absent “a compelling medical indication... interventions that might have irreversible consequences for the person’s sex or negative consequences on their sexuality or reproductive capability... should be left up to the affected persons themselves,” while at the same time “the family environment, the cultural context, and the preferred value system of the affected family must be given due consideration.” [50] Without exploring their own assumptions and beliefs, parents may not consider that their values conflict with their child’s best interests and right to autonomy. [52] The prioritizing of parental authority over child autonomy is implicit in current practices that allow parents to make irreversible decisions about the shape of their pre-verbal children’s genitalia.

Normalizing genital surgery is analogous to reparative or conversion therapy for LGBTQ people, which our AMA opposes (policy H-160.991), since it assumes *a priori* that genital difference is a pathologic state causing mental disorders. It is clear that the assumed risks of genital difference are psychosocial rather than physical. For example, in their ethics paper, Gillam et al describe the possibility of a “child... not [being] accepted by parents in the chosen sex of rearing, leading to impaired bonding; ... of social or cultural disadvantage to child, for example, reduced opportunities for marriage or intimate relationships or reduced opportunity for meaningful employment and capacity to earn an income; [and] of social isolation, restrictions or difficulties, for example caused by embarrassment or social stigma associated with having genitalia which do not match the gender in which the person lives.”[51] International experts even express pessimism regarding the widespread impact intact genitalia could have, not only on parents and children, but on “society.”[3, 34]

Lack of psychosocial support for families

The SPU states, “if surgery is considered, complete informed consent with counseling and support should be provided prior to proceeding with any surgical intervention” in a 2017 online post responding to the HRW/interACT report.[1] The reality of the current paradigm, which often presents new parents with options of doing surgery or doing “nothing,” is that it neglects the psychosocial component of health for distressed families who desperately want to help their children. [25] The lack of effective psychosocial

support means families often consent to early surgery in a state of emotional distress that impairs cognitive processing of information, and without a full understanding of the scientific, ethical, and human rights controversies surrounding these procedures. [53] Absence of a feasible psychoeducational care pathway leaves families “between a rock and a hard place,” with no meaningful alternative to surgery.[25] As one parent of a child with CCAH said, “It’s close to no choice... we figured that it had to be done.”[54]

Arguments over surgery as the primary measure to alleviate future psychosocial distress eclipse advocates’ primary mission: the development and implementation of effective psychosocial interventions, including routine inclusion of peer support, prior to irreversible decisions when the contemplated procedures violate human rights standards. [6] The need to address families’ emotional health was detailed in the original 2006 International Consensus Statement on Management of Intersex Conditions, which stressed psychosocial support. [55] While surgery may be helpful in some specific situations, criteria to define those who will benefit have not been defined. In the era of precision medicine, application of targeted measures used elsewhere in medicine such as behavioral phenotyping could improve the success of various psychosocial interventions. [56]

The availability of support is of international concern. A German survey of parents found that although 40% of parents of children with DSD expressed a subjective need for psychological support, only about half of those parents received it adequately or partly, and half needed it but received no support. [57] In the US, where in a recent practice survey of multidisciplinary teams by the NIH-funded Translational Research Network (TRN) reported that psychologists or psychiatrists are always available or available by consult, 1/3 of families still lack routine access to psychological services. [58] Among barriers requiring urgent attention are the limited number of behavioral health providers with specialized training and experience, lack of reimbursement, and few centers providing services promoting acceptance of differences. [6] A needs analysis of international counselors involved in intersex care revealed significant unmet needs. [52] Most were counseling parents rather than children or adults, and felt that current systems do not adequately address concerns with gender dissatisfaction, confusion, reassignment and cross-gender behavior, which are much stronger than results of parent and patient satisfaction surveys indicate. They endorsed expertise in sexual issues and collaboration with sex therapists, with an emphasis on acceptance of genital difference, to reinforce coping and resilience. [52] Replacing irreversible surgery with a dynamic approach prioritizing psychosocial interventions could address potential consequences of genital difference that are expected to vary with life stages. Dealing with issues raised by families, children, adolescents and adults will require clinicians to confront unconscious assumptions and overcome systemic barriers to prioritizing psychosocial care within teams. [59]

Allowing children to grow up with intact genitalia that may not match their gender identity is not a form of “social experimentation.” Parent acceptance of deferred surgery is confirmed by early encouraging results from a study of parents favoring initial endocrine treatment, indicating that “so far girls and their parents have not experienced significant concerns regarding genital ambiguity.”[60] In non-intersex children, increased rates of suicide and self-harm are observed in adolescents with gender dysphoria, who by definition have genitalia discordant with their gender identity, but well-known research demonstrates that support for identity and social transitioning are primary factors promoting self-esteem and mental health. [61] [62] Living with discordant genitalia is not the primary challenge to their mental health.

Psychosocial consequences of genital difference

Stigma in adults with CCAH, which surgery is meant to prevent, has recently received attention. [3] Several recent studies documented that stigma was experienced by adult women with CCAH in a variety of settings, even though most of the women had previous surgery. [28,29,30] Stigma experienced by nearly 2/3 of adults in the general social environment was related to obvious physical differences, such as hirsutism or a deep voice, rather than genital difference.[63] 25% of the same women reported that doctors’ actions caused stigma, mostly via frequent genital exams in teaching settings. [64] This is a significant finding because despite years of patient complaints about traumatizing genital exams, the practice continues in contemporary multidisciplinary clinics, of which the TRN found that 30% still perform genital exams for teaching. [58] Sexual stigma was experienced by 40% of the women studied, whether they had surgery (the

majority) or not, but nearly all women described maladaptive coping in interviews, including secrecy, hiding genitalia, sex avoidance or abstinence, and substance abuse. [28] Rather than being a consequence of genital difference, shame can result from the mere fact of having genitals that “required surgery,” suggesting significant iatrogenic moderators of the relationship between genital difference and sexual stigma. [28]

Studies of adults with CCAH show that surgery does not avert psychiatric issues, which are increased relative to the general population. One study found significantly increased rates of counseling for severe symptoms, and a multicenter European study found 8.8% had longstanding psychological problems. [65, 66]. The types of problems observed in adults include depressive mood disorders and anxiety [67, 68], suicidality,[66, 69] and paranoid ideation.[70]

Reports of psychometric test results, stigma, and psychiatric diagnoses do not capture the full spectrum of challenges to wellbeing in adults, including barriers to intimacy, evolving identities, and poor education about their medical and surgical histories. [59] In a qualitative study, many adults felt that CCAH had a strong negative impact on their lives, with over half saying their sexual lives were severely affected. [71] Narrative analysis of patient accounts reveals that many who endure serious ongoing trauma are in fact thriving, which should prompt us to regard them as “survivors.” [72] The single biggest factor in thriving was finding peer support. [72] Collaborative research with those who are doing well could investigate factors known to promote thriving in survivors of other types of trauma such as childhood cancer and abuse.[72]

FG proponents acknowledge the need for some form of intersex-related psychosocial intervention in some women, but demur on actual recommendations such evidence since there is little evidence for effectiveness of specific interventions in CCAH. Social and professional psychological support have been found to positively impact adult well-being. [73] A needs assessment study of a group of men with the DSD congenital hypogonadotropic hypogonadism, or Kallmann syndrome, found that patients are receptive to online interventions aimed at addressing their unmet needs, including peer support to enhance coping and promote health.[74]

Informed consent

The way in which intersex is presented influences parent attitudes. Streuli et al conducted a study of the effects of contrasting professional counselling behaviors on decision-making; 2 groups of 3rd-year medical students functioning as proxies for parents were assigned randomly to watch one of 2 videos, the first a medicalizing presentation discussing “disorders,” “congenital malformation,” and “surgical options,” and the second emphasizing less pathologizing, more supportive information. When asked to decide for or against early surgery, 2/3 of those who watched the medicalizing video and 1/4 of those who watched the demedicalizing video chose surgery. [75] Significantly, neither group felt the presentation influenced their decision.

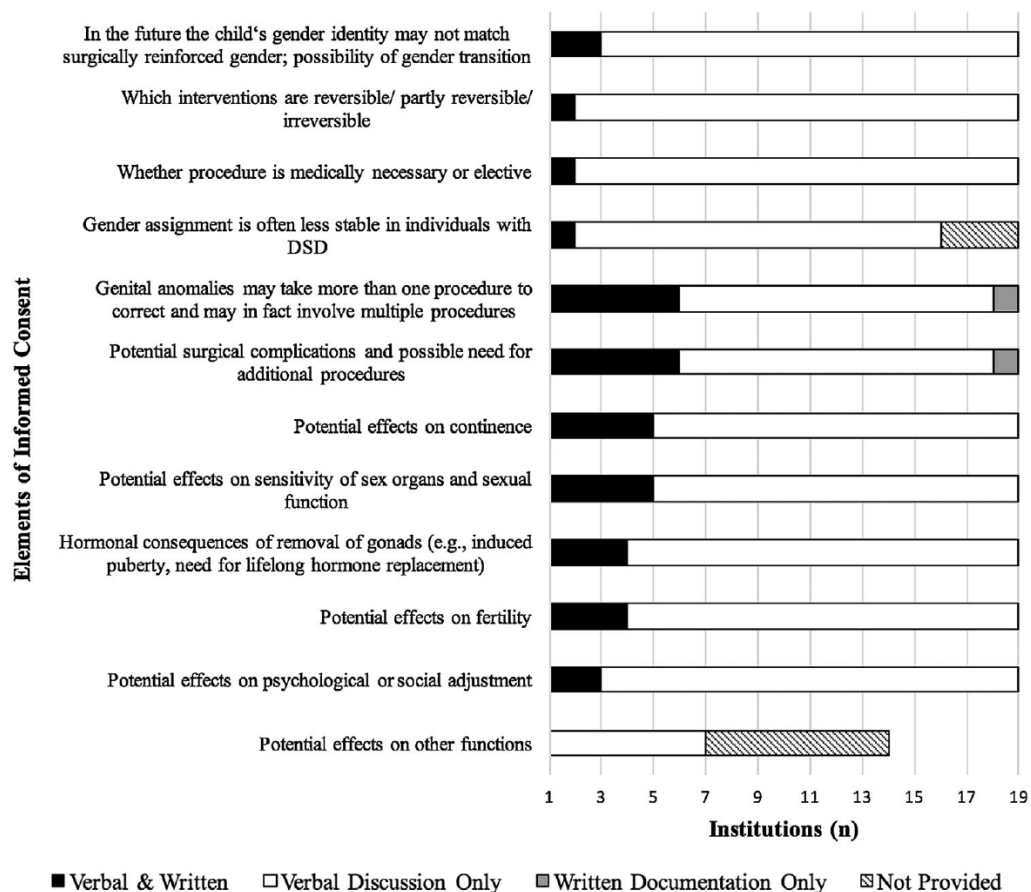
The SPU affirms that “societal norms do not dictate whether a child may be a candidate for surgery,” but doctors themselves are an important repository of the beliefs and values that reflect societal norms. [1] Female genital mutilation and FG are sometimes compared because, although they are performed for very different reasons, either can result in anger and resentment over their imposition at a time when children are too young to understand, and subsequent powerful negative emotions can impair sexuality beyond the purely physical sequelae of either intervention. [76] While noninvasive “pricking” of the clitoris of Muslim girls is prohibited in the US because it is culturally motivated, surgeons admit that they sometimes perform FG because of “cultural concerns.” This suggests that some physicians have a troubling double standard of “acceptable” and “unacceptable” cultural motivations based on race, ethnicity or immigration status. [76]

Overwhelmed families who may not have previously considered their feelings about genital difference are distressed, anxious, and protective toward their children [54, 77-79]. In a vacuum of previous experience with genital difference, they may unknowingly be influenced by implicit clinician attitudes. There has been no systematic investigation of the foundation of physician attitudes, but in *Fixing Sex*, Karkazis found that some physicians expressed disgust toward “ambiguous” genitalia. [9] In a qualitative study of clinicians

designed to build on the research of Streuli et al, Roen and Hegarty interviewed 32 clinicians involved in the care of children with genital difference. They found that institutional practices such as automatic referral to surgeons leave parents terrified that something is wrong with their child, and that clinicians themselves did not realize the impact of their personal beliefs (that parents want surgery) and parents' expectations (surgery can fix anything) on their discussions with families. [80] The presentation of "doing nothing" as the alternative to surgery can seem unacceptable to families in the face of strong norms in favor of surgery, especially when the choice is repeatedly presented. They concluded that clinicians underestimate the effect of framing in influencing parental decisions. Noting that some psychological specialists are actively framing genital difference in ways that support parents' abilities to raise happy, flourishing children with unconditional love, and focusing on cultivating psychological health, well-being, and self-esteem, they suggested that a psychosocial approach to genital difference would frame genital difference in non-medicalizing ways in discussions with parents.

In addition to questions of framing, current informed consent practices may exclude information that intersex people themselves believe parents should know. For an NIH-funded Translational Research Network (TRN) study of clinical practice, intersex advocates created a list of key points of information to be discussed with families considering genital or gonadal surgery for their children which was used to survey centers on informed consent practices. While centers believed they had discussed most of these points, this chart summarizes how few actually documented what they told parents, especially regarding medical necessity, irreversibility, and gender uncertainty. [58] (see Figure 1.)

Figure 1. How specific elements of informed consent are documented by multidisciplinary teams.
(Reproduced with permission from Aimee Rolston)



In retrospective surveys like this, the content of discussions is subject to recall by families and clinicians. Without a formal education process, guidelines, documentation, or assessment of parent knowledge, there is a strong possibility that many parents may not have received or understood important information. Even if they did, only half the centers imposed a thinking period before surgery to allow families to assimilate complex information.[58] Looking at physician influence and consent from another perspective, in a prospective study of postoperative cosmesis that did not specify elements of informed consent, 30% of mothers and 50% of fathers who were invited to participate were satisfied with the preoperative appearance of their children's genitals, while 100% of surgeons were dissatisfied/very dissatisfied. [31] Despite the rate of parental satisfaction, 96% of families agreed to surgery. [31] Rates of consent that parallel surgeons' rather than parents' dissatisfaction with appearance may reflect surgeons' attitudes toward necessity, raising questions of how genital difference is framed and of how "informed" consent actually is in the face of surgeons' preference for early surgery.

Analysis of specific arguments for early surgery

Evidence underlying several assertions that arise repeatedly in support of early FG deserves additional exploration.

Gender dysphoria is unusual in CCAH

Regarding the background prevalence of GD in the general population, CDC's Behavioral Risk Factor Surveillance System recent data analysis estimates that 0.7% of youth in the general population identify as trans. [81]

Publications favoring early FG in CCAH contain statements such as, "female assignment is suggested for those with 46,XX and CAH, since 95% develop female gender identity," or "there is usually no gender issue in this group," but the literature in this area is seriously flawed. [3, 34] In children with CCAH, as in all children, gender identity is a result of "complex, multiple and interactive developmental processes." [82] It is not fixed at birth, nor is it confirmed by "fixing" genitals with surgery aimed at creating dimorphism.

FG proponents minimize the significance of surgical reinforcement of gender misassignment with claims that multiple studies show a low rate of GD in CCAH. A 2015 literature review by Pasterski found the results of older studies often cited as supporting early surgical reinforcement of female gender assignment are unreliable because they used flawed methodologies including inconsistent, insufficient, or unvalidated measurements; even those using measurements based on DSM-IV or self-report questionnaires/ interviews confounded gender identity with gender role behaviors. [83] Among those discredited studies is one that is frequently cited by surgery proponents for its numerical significance, a 2005 literature analysis by Dessens et al that reports on 250 people. [84] Similarly, in a 2018 study, "Gender Dysphoria and Gender Change in Disorders of Sex Development/Intersex Conditions: Results from the dsd-LIFE Study," which is the largest investigating gender outcomes in intersex/DSD, the data collected ostensibly show a 0.4% rate of GD in CAH, but the authors themselves caution that multiple methodologic issues challenge the study's validity. [85] Although it was a mixed methods study, quantitative questionnaires were not developed on the basis of clinical interviews. Of 221 female-assigned participants with CAH, 174 had confirmed CCAH, but 47 were not specified. "Because their gender did not correspond with the usual gender for their diagnosis," those living as male were excluded. Finally, 36% of scores on questions meant to assess GD were missing; only questions on recent sexual activity had a similar rate of missing responses.

In order to avoid methodologic limitations, Pasterski et al performed their own study *prospectively* assessing gender identity of 81 female-assigned 4- to 11-year old children using mixed qualitative and quantitative methods, including the existing gold standard, DSM 4 criteria for gender dysphoria (GD). [83] They found that cross-gender identification was significantly increased in these children relative to both XY siblings with CAH and unaffected siblings. The results in 12% of female-assigned children met all 5 DSM criteria for GD, qualifying them for referral to a GD clinic. 12% is not rare; it equates to 1 out of 8 patients, the same as the

proportion of women who will develop breast cancer in their lifetimes, which is not considered unusual. It is also nearly 20 times higher than the rate of GD in non-intersex children.

Among all studies of adult gender identity outcomes, there is one that stands out for utilizing the type of mixed methods- interviews plus quantitative scales developed from those interviews- recommended by the IRDiRC for research on rare conditions. [26] Schweizer et al studied 69 people with diverse intersex/DSD, including 17 patients with CCAH. [86] Although the sample size is small, the investigation yielded details unmatched in richness, providing complex and nuanced insights not found in other studies. Among those 17 patients, with one non-responder, 11/16 (69%) identified as women, 4/16 (25%) reported a 'mixed' two-gender identity and 1/16 (6%) a male gender identity. 10 of 12 of those originally assigned female (2 born with female genitalia and 8 with ambiguity), were fairly to highly satisfied with assignment (83%). Among the satisfied 10, however, 1 had mixed identity. Of the 2 (17%) not satisfied with female birth assignment, both had genital ambiguity; 1 was reassigned male at age 7 based on medical recommendations following signs of male development, and continued living as male but had a mixed 2 gender identity. The other person not satisfied with female assignment had mixed identity and lived in a 3rd gender in adulthood. 5 people were assigned male before age 1, 4 having male genitalia; 1 (20%) was ultimately satisfied and lived in a male role. Two who were reassigned female before age 2 (1 with ambiguous and 1 with male genitalia at birth) later identified and lived as female. One person with male genitalia at birth and assigned male, who was reassigned female before age 1 and self-reassigned male at 35, had mixed gender identity and lived in a 3rd gender; they stated, "The definition as female and the iatrogenic trauma connected with it destroys identity." [86] The 5th person assigned male, who had male genitalia at birth and underwent many medical male-sex-assigning interventions, later identified as female and was considering a male to female gender transition.

The results show that gender assignment based on genital appearance alone is not predictive of adult gender identity. There is significant dissatisfaction with gender assignment, both male and female, even in the absence of gender transition. Among the study's surprising findings was that 7/16 (41%) people, including some who were satisfied with gender assignment, had markedly low scores on the certainty of belonging to one specific gender (CG) scale. Schweizer et al concluded that their findings indicate

"... the inadequacy of the dichotomous, one-dimensional male/ female 12categorization for the purpose of allowing an authentic sense of gender identity in individuals with DSD. Our research further suggests that treatment goals should be re-directed from 'successful' gender outcome in binary terms to psychological well-being regardless of feeling male, female, both or neither.

Though the [2006] consensus statement [55] offers useful suggestions for clinical management, a fundamental weakness lies in its perpetuation of 'optimal gender' thinking (e.g. 'successful gender assignment is dependent on this procedure [phalloplasty]'. [55] Whilst prediction of adult gender identity remains illusive, social allocation of a gender to facilitate gender identity development should continue. However, non-emergency sex-assigning interventions should be the subject of much tighter scrutiny." [86]

The finding that 25% of people with CAH have identities not encompassed in current terminology makes it clear that more expansive understandings of gender as dynamic and non-binary are needed. [86] With errors in early childhood gender assignment a significant possibility, deferring surgery in children preserves options for later transition. Social assignment is easily changed, but irreversible surgery compounds the magnitude of harm from misassignment to catastrophic proportions, as in the removal of a healthy penis from a child subsequently identifying as male.

Surgery that spares neurovascular structures will preserve sensation and function

Over-optimism regarding surgical outcomes is pervasive. In a typical argument for continuing to offer early surgery to families, while "each child's diagnosis and treatment options are presented to parents based on best available science," evidence regarding the most up-to-date procedures is lacking because patients

presented in recent reports “were treated decades before physicians began to specialize in pediatric urology, and many of the related procedures are no longer being performed.” [87] Since today’s surgery is technically more advanced, “current study results do not support abandonment of childhood genital reconstruction.” [88] In other words, since functional outcomes of today’s procedures will not be known for 15-20 years, data invalidating the prediction of superior outcomes will be irrelevant, because there will be even more sophisticated techniques by that time, permitting endlessly unproven speculation to fuel the continued practice of early FG. In the face of data on poor outcomes, because we will not know the outcomes of today’s surgery for many years, the supposed benefits of early surgery justify its continued execution. Advocates of delaying surgery point out that postponement respects children autonomy and allows future access to expanded knowledge and improved procedures.

One particular unsupported contention is the belief that preservation of neurovascular structures assures better outcomes. The anatomic knowledge underpinning modern “neurovascular-sparing” surgery, according to proponents, is derived from 2 papers elucidating clitoral anatomy published by Baskin et al in 1999. [7, 89, 90] The original papers describe typical human fetal genital anatomy; but a hypothesis that atypical “masculinized” female anatomy should parallel typical human male anatomy replaces an actual demonstration of atypical anatomy in CCAH. [89, 90] Since actual specimens of “masculinized” human fetuses with CCAH were unavailable to confirm this idea, Baskin’s group sought an animal model. They chose the female spotted hyena, which has unusually high androgen levels, and has a long phallus-like clitoris through which it urinates, copulates and delivers young. Proof of concept was reported when fetal female hyena anatomy was correlated with predictions of how “masculinization” would affect the developing human clitoris. [91] However, the spotted hyena urogenital sinus (UGS) is intrinsically very different from the UGS in CCAH. The relevance of hyena neurovascular anatomy to FG in CCAH is questionable because hyena clitoris does not provide sexual pleasure, which is the sole purpose of the human clitoris. While the hyena UGS extends the entire length of the clitoris, the human UGS opens on the perineum in CCAH. Unlike androgen-mediated clitoral development in fetuses with CCAH, development of the “masculinized” female hyena clitoris is androgen-independent: female offspring of pregnant hyenas given androgen-blockers have clitorises that are not significantly different from untreated offspring. [92] . The cephalad orientation of the hyena UGS opening limits sexual access of potential mates; limited clitoral distensibility requires significant tearing to accommodate delivery and causes frequent entrapment of hyena pups in the UGS during birth, with a 60% rate of stillbirth in first-time deliveries. [92] Despite these fundamental functional and developmental differences, FG techniques are still based on the correlation of hyena and human anatomy.

Beliefs that that procedures preserving the predicted locations of neurovascular structures will protect sexual sensation and function persist despite histologic demonstration of branches of the dorsal nerve in 23 of 27 clitoral tissue specimens removed during nerve-sparing clitoroplasty by Poppas’s group; they described those nerves as insignificant. [93] Their subsequent study of functional outcomes prompted outrage when Poppas et al published a report in which young children’s postoperative sensitivity was assessed using a cotton tip applicator and a vibratory device to test genital sensation at various points of the inner thigh and genitalia- labia majora, labia minora, vaginal introitus and clitoris. [94] As a leading psychologist commented at the time, “Applying a vibrator to a six-year-old girl’s surgically feminized clitoris is developmentally inappropriate.” [95] A complaint was filed with the Office for Human Research Protections (OHRP) in 2010 by Alice Dreger, Advocates for Informed Choice and others, asserting that the research was unethical, not IRB-approved, and could psychologically harm children with no direct benefit to them. [95] [96] Although Poppas wrote in response to a 2017 inquiry by Human Rights Watch (HRW) that he discontinued clitoral sensitivity testing in 2006, he was observed discussing it with parents as part of surgical follow up in 2015. [20, 97, 98] The complaint was eventually dismissed by OHRP on the grounds that the research was not federally funded. [99] Today, claims of intact postoperative clitoral sensation with current early FG techniques remain unconfirmed because of varying surgical procedures and assessment techniques. [100, 101]

Early surgery is better

Supporters of early FG agree with advocates of deferral that there are currently insufficient data to support assertions that adult women are satisfied with the results of early surgery.[28] Since there is no research

directly comparing outcomes of early and late FG, we cannot know which is better, although some gynecologists who perform both primary FG and surgery to treat subsequent complications in older patients advocate for deferral. [2] [29] Unsupported assertions of superiority of early FG distract from the uncomfortable truth that pediatric specialists themselves prefer it because they are not trained to perform surgery in older, consenting individuals. [1] Six-year follow up of successful single-stage adult genitoplasty with preservation of orgasm was reported by Tjalma in 2016; the operation preserving the erectile tissue of the corpora cavernosa in a previously-orgasmic woman with CCAH also eliminated the need for revision vaginoplasty because the woman was already sexually active.[30]

Although many retrospective studies of FG opine that outcomes should be improved when surgery is performed by expert surgeons in the ideal setting of multidisciplinary care, a recent prospective study of outcomes of modern neurovascular-sparing surgery in that setting does not show the hoped-for reduction in complications: after just one year, 10% of FG procedures had serious complications. [18] The short-term complication rate for proximal hypospadias surgery, also a controversial procedure, was 40%, consistent with statistics for these procedures performed in other settings.[18, 32]

While some centers support early surgery with anecdotal evidence of adult CCAH patients requesting primary or revision surgery, there are corresponding anecdotes of unoperated intersex adults who are grateful to have been spared infant surgery, such as 60-year-old Jim Costich, who posted on Facebook: “I did not have any genital surgery to make me look any different and... my love life, my social life, my gym life, even my life as a nudist has not been adversely affected!”

Surgery on older children and adolescents must still be approached carefully. The lessons of adolescent labiaplasty remind us that there is a strong developmental urge to erase variation and conform to unrealistic cosmetic standards promoted by social media. As the American College of Obstetrics and Gynecology states, psychosocial services and counseling are essential: “Although reconstructive procedures aimed at correction of abnormalities (caused by congenital defects, trauma, infection, or disease) or cosmetic procedures performed to reshape normal structures may improve function, appearance, and self-esteem, not all adolescents are suited for surgical intervention. Appropriate counseling and guidance of adolescents with these concerns require a comprehensive and thoughtful approach, special knowledge of normal physical and psychosocial growth and development, and assessment of the physical maturity and emotional readiness of the patient.” [102]

FG is reversible

This claim is based on a technique described by Pippi Salle et al in 2007. Noting that patients undergoing FG for CAH may have gender dysphoria later in life and wish that they could reverse decisions made by parents and caregivers earlier in their lives, Pippi Salle et al introduced corporeal sparing dismembered clitoroplasty as a conservative technique intended to preserve all clitoral structures, providing potential for surgical transition back to an intact phallus. [103] Although a PubMed search shows that the technique is referenced in 6 papers, none is an outcomes study. Nonetheless, 2 prominent proponents of FG present it in a 2017 review among cutting-edge techniques. [11]

Adult women and parents prefer early surgery

The oft-repeated contention that women “clearly” prefer early surgery relies on uncritical acceptance of the conclusions of very few studies, and is contradicted by closer scrutiny of the actual study methods and data. [104, 105] One of these studies included the following question: “Some people argue that children born with unfinished sex organs (ambiguous genitalia) should not be surgically corrected before they are adult and can fully understand and consent to the procedures. Do you agree?” [106] Framing genital difference inaccurately as “unfinished sex organs” could promote a bias in responses. Also, those who “preferred” early surgery were not informed of the alternative of not having surgery at all; that delaying surgery could have reduced the rate of reoperation for vaginal stenosis; or that there had been significant technical modernizations predicted to improve outcomes since their early childhood surgery. [104] As for parents, families who chose early FG because it was presented as helpful and necessary would be expected to wish it

had been done even earlier. [100, 107]

Surgery prevents UTIs

It was commonly believed in the past that early FG prevents UTIs, as in 2002 Pediatric Endocrine Society guidelines. [108] Today we know that girls with CAH who have a common urogenital sinus are not predisposed to UTI prior to surgery, and an intact urogenital sinus does not predispose to UTI later. [108, 109] In spite of these facts, many families continue to testify anecdotally that they have been told FG will prevent UTI. Surgery also does not prevent significant non-infectious urinary issues. In long-term follow up of adults, whether they had surgery or not, adults with CCAH were more likely to have urinary symptoms, particularly incontinence, than age-matched controls, and those with urinary symptoms were 9 times as likely as symptomatic controls to report an adverse effect on their lives. [14]

Conclusion

Children have borne the risk of “disappointing” surgical results of FG for decades. The current costly paradigm, in which many children with certain anatomic features undergo surgery to prevent presumed psychosocial issues, even though we know that some of them will experience a lifetime of serious harm, is neither ethical nor practical and violates children’s human rights. Families remain bewildered and underinformed in the current situation. As a doctor who has been a patient, I come to our AMA because the bedrock of the doctor-patient relationship is truthfulness. Families who choose early FG in CCAH don’t understand what a 1 in 8 chance of involuntary sex reassignment means, nor are they thoroughly educated about the other long-term risks and complications that intersex people themselves think they should know.

The debate over the current resolution highlights that although all stakeholders in the care of children with genital variation want what is best, polarized viewpoints on treatment reflect the values, priorities, and experience they bring to the situation. The medicalized perspective relies on studies with serious limitations, including nonadherence to principles of research for rare conditions and lack of community participation in study design. Absence of long-term follow up of patients, many of whom may be alienated by stigmatizing medical experiences, is reflected in both research outcomes and in many doctors’ personal experience. The validity of existing studies is also restricted by low participation rates and unsuitable methodologies. Consequently, there are no data showing that deferring surgery and implementing psychosocial interventions is noninferior to early FG. Continuing the status quo until more and “better” research is done, and suggesting that changing current practice to defer surgery requires proof that *not* performing early FG is not harmful, does not constitute evidence-based medicine.

Our AMA already opposes conversion therapy based upon the assumption that homosexuality is a mental disorder. Early FG to avert mental health problems assumed to be intrinsic to genital difference deserves the same consideration. I ask our AMA to support this resolution that promotes patient-centered medical care by giving children an open future with time to learn who they are before they undergo any irreversible surgery, providing parents a meaningful psychoeducational alternative, and encouraging doctors to develop effective psychosocial interventions that support children’s right to autonomy and self-determination.

References

1. *Physicians recommend individualized, multi-disciplinary care for children born 'intersex'*. 2017 3/9/2018]; Available from: <http://www.spuonline.org/HRW-interACT-physicians-review/>.
2. Creighton, S., et al., *Timing and nature of reconstructive surgery for disorders of sex development - introduction*. J Pediatr Urol, 2012. **8**(6): p. 602-10.
3. Mouriquand, P.D., et al., *Surgery in disorders of sex development (DSD) with a gender issue: If (why), when, and how?* J Pediatr Urol, 2016. **12**(3): p. 139-49.

4. Braga, L.H. and J.L. Pippi Salle, *Congenital adrenal hyperplasia: a critical appraisal of the evolution of feminizing genitoplasty and the controversies surrounding gender reassignment*. Eur J Pediatr Surg, 2009. **19**(4): p. 203-10.
5. Nordenström, A., *Commentary to "Secondary vaginoplasty for disorders of sex development: is there a right time? Challenges with compliance and follow-up at a multidisciplinary centre"*. J Pediatr Urol., 2013 Oct. **9**(5): p. 632-3.
6. Ernst, M.M., et al., *Disorders of Sex Development/Intersex: Gaps in Psychosocial Care for Children*. Pediatrics, 2018.
7. Wang, L.C. and D.P. Poppas, *Surgical outcomes and complications of reconstructive surgery in the female congenital adrenal hyperplasia patient: What every endocrinologist should know*. J Steroid Biochem Mol Biol, 2017. **165**(Pt A): p. 137-144.
8. Roth, J.D., et al., *Characteristics of Female Genital Restoration Surgery for Congenital Adrenal Hyperplasia Using a Large-scale Administrative Database*. Urology, 2018. **115**: p. 162-167.
9. Karkazis, K., *Fixing Sex: Intersex, Medical Authority and Lived Experience*. 2008, Durham, NC: Duke University Press.
10. *Age, insurance status related to hospitalization for children with congenital adrenal hyperplasia*. Endocrine today. 2017; Available from: <https://www.healio.com/endocrinology/adrenal/news/in-the-journals/%7B3e2b34c8-070b-42ed-87f9-8489f8f0a1d2%7D/age-insurance-status-related-to-hospitalization-for-children-with-congenital-adrenal-hyperplasia>.
11. Kaefer, M. and R.C. Rink, *Treatment of the Enlarged Clitoris*. Front Pediatr, 2017. **5**: p. 125.
12. Dangle, P.P., et al., *Surgical Complications Following Early Genitourinary Reconstructive Surgery for Congenital Adrenal Hyperplasia-Interim Analysis at 6 Years*. Urology, 2017. **101**: p. 111-115.
13. Stites, J., et al., *Urinary continence outcomes following vaginoplasty in patients with congenital adrenal hyperplasia*. J Pediatr Urol, 2017. **13**(1): p. 38 e1-38 e7.
14. Davies, M.C., et al., *Congenital adrenal hyperplasia and lower urinary tract symptoms*. BJU Int, 2005. **95**(9): p. 1263-6.
15. Crouch, N.S., et al., *Sexual function and genital sensitivity following feminizing genitoplasty for congenital adrenal hyperplasia*. J Urol, 2008. **179**(2): p. 634-8.
16. *FDA Drug Safety Communication*. FDA approves label changes for use of general anesthetic and sedation drugs in young children. 2017 4/27/2017; Available from: <https://www.fda.gov/Drugs/DrugSafety/ucm554634.htm>.
17. Schneuer, F.J., et al., *The impact of general anesthesia on child development and school performance: a population-based study*. Paediatr Anaesth, 2018. **28** (6). <https://doi.org/10.1111/pan.13390>
18. Bernabé, K.J., et al., *Preliminary report: Surgical outcomes following genitoplasty in children with moderate to severe genital atypia*. J Pediatr Urol, 2018: p. 1.e1- 1.e8.
19. Webb, E.A., et al., *Quantitative Brain MRI in Congenital Adrenal Hyperplasia: In Vivo Assessment of the Cognitive and Structural Impact of Steroid Hormones*. J Clin Endocrinol Metab, 2018. **103**(4): p. 1330-1341.
20. *"I Want to be Like Nature Made Me": Medically Unnecessary Surgeries on Intersex Children in the US*. © 2017 by Human Rights Watch; Available from: https://www.hrw.org/sites/default/files/report_pdf/lgbtintersex0717_web_0.pdf.
21. Monteleone, M., et al., *Anesthesia in children: perspectives from nonsurgical pediatric specialists. Supplement: Fourth PANDA Symposium*. J Neurosurg Anesthesiol, 2014. **2014**(26): p. 396-398.
22. Andropoulos, D. and M. Greene, *Anesthesia and Developing Brains — Implications of the FDA Warning*. N Engl J Med, 2017. **376**: p. 905-907.
23. AAN. *Advisory Advisory Network letter of resignation from NIH Translational Research Network*. 11/24/2015; Available from: <https://interactadvocates.org/wp-content/uploads/2018/01/AAN-letter-of-resignation-.pdf>.
24. U.S. Department of Health & Human Services. National Institutes of Health. Division of Program Coordination, Planning, and Strategic Initiatives (DPCPSI). *News Announcement: Sexual and Gender Minorities (SGM) are officially designated as a Health Disparity Population (HDP) for NIH research*. 2018.; Available from: <https://dpcpsi.nih.gov/sgmro>.
25. Liao, L.M., D. Wood, and S.M. Creighton, *Parental choice on normalising cosmetic genital surgery*. BMJ, 2015. **351**: p. h5124.

26. Morel, T. and S.J. Cano, *Measuring what matters to rare disease patients - reflections on the work by the IRDiRC taskforce on patient-centered outcome measures*. Orphanet J Rare Dis, 2017. **12**(1): p. 171.
27. Regnault, A., et al., *Towards the use of mixed methods inquiry as best practice in health outcomes research*. J Patient Rep Outcomes, 2017. **2**(1): p. 19.
28. Meyer-Bahlburg, H.F.L., et al., *Stigma Associated with Classical Congenital Adrenal Hyperplasia in Women's Sexual Lives*. Arch Sex Behav, 2017. DOI 10.1007/s10508-017-1003-8.
29. Murphy, C., L. Allen, and M.A. Jamieson, *Ambiguous genitalia in the newborn: an overview and teaching tool*. J Pediatr Adolesc Gynecol, 2011. **24**(5): p. 236-50.
30. Tjalma, W.A.A., *Assembling a Functional Clitoris and Vulva from a Pseudo-Penis: A Surgical Technique for an Adult Woman with Congenital Adrenal Hyperplasia*. J Pediatr Adolesc Gynecol, 2017. **30**(3): p. 425-428.
31. Nokoff, N.J., et al., *Prospective assessment of cosmesis before and after genital surgery*. J Pediatr Urol, 2017. **13**(1): p. 28 e1-28 e6.
32. Long, C.J. and D.A. Canning, *Proximal hypospadias: we aren't always keeping our promises*. F1000Research 2016, 2016. **5**.
33. Nördenstrom, A., *Psychosocial Factors in Disorders of Sex Development in a Long-Term Perspective: What Clinical Opportunities are there to Intervene?* Horm Metab Res, 2015. **47**(5): p. 351-6.
34. Lee, P.A., et al., *Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care*. DOI 10.1159/000442975. Horm Res Paediatr, 2016.
35. *UNFE Intersex Fact Sheet*. Free and Equal: United Nations for LGBT Equality 2015; Available from: https://www.unfe.org/system/unfe-65-Intersex_Factsheet_ENGLISH.pdf.
36. WHO. *Sexual health, human rights and the law*. Human reproduction programme 2015; Available from: http://apps.who.int/iris/bitstream/handle/10665/175556/9789241564984_eng.pdf;jsessionid=0903E8FBEC246D7B5D8B6B8EEB5986B7?sequence=1.
37. *Providing ethical and compassionate health care to intersex patients. Intersex-affirming hospital policies*. 2018 7/19/2018; Available from: <https://www.lambdalegal.org/publications/intersex-affirming>.
38. *US Department of State. In recognition of intersex awareness day*. 2017 10/26/2017; Available from: <https://www.state.gov/r/pa/prs/ps/2017/10/275098.htm>.
39. Strangio, C. *Stop Performing Nonconsensual, Medically Unnecessary Surgeries on Young Intersex Children* 2017 10/26/2017; Available from: <https://www.aclu.org/blog/lgbt-rights/stop-performing-nonconsensual-medically-unnecessary-surgeries-young-intersex>.
40. Harris, P., *Supporting Autonomy for Patients with Differences of Sex Development (DSD) (Resolution 3-A-16)*. 2016, American Medical Association.
41. Toler, J. *Medical and Surgical Intervention of Patients with Differences in Sex Development*. [Policy statement.] 2016 10/03/2016 3]; Available from: <http://glma.org/index.cfm?fuseaction=document.viewdocument&ID=CEB9FEE4B8DD8B7F4F7575376BD476C3A433379DD853BEA17913AFCCB8270299C0731320B03D2F5E1022F1C15602FBEA>.
42. Elders, M.J., D. Satcher, and R. Carmona. *Re-Thinking Genital Surgeries on Intersex Infants*. The Palm Center Blueprints for Sound Public Policy 2017; Available from: <https://www.palmcenter.org/wp-content/uploads/2017/06/Re-Thinking-Genital-Surgeries-1.pdf>.
43. Venters, H. *Unnecessary Surgery on Intersex Children Must Stop*. 2017; Available from: <http://physiciansforhumanrights.org/press/press-releases/intersex-surgery-must-stop.html>.
44. AMSA. *AMSA Issues Statement to Defer Gender "Normalizing" Surgeries for Children Born as Intersex*. 2017, American Medical Student Association.
45. AAFP. *Genital Surgeries in Intersex Children*. 2018, American Academy of Family Physicians.
46. *Reference Committee on Amendments to Constitution and Bylaws. Michigan resolution: 013 (A-18). Opposing Surgical Sex Assignment of Infants with Differences of Sex Development*. 2018: AMA House of Delegates.
47. *California Senate concurrent resolution SCR-110*. 2018; Available from: https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SCR110.
48. Feder, E.K. and A. Dreger, *Still ignoring human rights in intersex care*. J Pediatr Urol, 2016. **12**; p. 436-37.

49. Kon, A.A., *Ethical issues in decision-making for infants with disorders of sex development*. Horm Metab Res, 2015. **47**(5): p. 340-3.
50. Wiesemann, C., et al., *Ethical principles and recommendations for the medical management of differences of sex development (DSD)/intersex in children and adolescents*. Eur J Pediatr, 2010. **169**(6): p. 671-9.
51. Gillam, L.H., J.K. Hewitt, and G.L. Warne, *Ethical principles for the management of infants with disorders of sex development*. Horm Res Paediatr, 2010. **74**(6): p. 412-8.
52. Dessens, A., et al., *Understanding the needs of professionals who provide psychosocial care for children and adults with disorders of sex development*. BMJ Paediatr Open, 2017. **1**(1): p. e000132.
53. Tamar-Mattis, A., et al., *Emotionally and cognitively informed consent for clinical care for differences of sex development*. Psychology & Sexuality, 2013. **5**(1): p. 44-55.
54. Boyse, K.L., et al., *"It was an overwhelming thing": parents' needs after infant diagnosis with congenital adrenal hyperplasia*. J Pediatr Nurs, 2014. **29**(5): p. 436-41.
55. Lee, P.A., et al., *Consensus statement on management of intersex disorders*. International Consensus Conference on Intersex. Pediatrics, 2006. **118**(2): p. e488-500.
56. Kangovi, S. and D.A. Asch, *Behavioral Phenotyping in Health Promotion: Embracing or Avoiding Failure*. JAMA, 2018. **319**(20): p. 2075-2076.
57. Bennecke, E., et al., *Subjective need for psychological support (PsySupp) in parents of children and adolescents with disorders of sex development (dsd)*. European Journal of Pediatrics, 2015. DOI 10.1007/s00431-015-2530-8.
58. Rolston, A.M., et al., *Disorders of sex development (DSD): Clinical service delivery in the United States*. Am J Med Genet C Semin Med Genet, 2017. **175**(2): p. 268-278.
59. Liao, L.-M. and M. Simmonds, *A values-driven and evidence-based health care psychology for diverse sex development*. Psychology & Sexuality, 2013. **5**(1): p. 83-101.
60. Bougnères, P., et al., *Deferring surgical treatment of ambiguous genitalia into adolescence in girls with 21-hydroxylase deficiency: a feasibility study*. Int J Pediatr Endocrinol, 2017. **2017**.
61. Olson, K.R., et al., *Mental Health of Transgender Children Who Are Supported in Their Identities*. Pediatrics, 2016. **137**(3): p. 1-8.
62. Durwood, L., K.A. McLaughlin, and K.R. Olson, *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*. J Am Acad Child Adolesc Psychiatry, 2017. **56**(2): p. 116-123.e2.
63. Meyer-Bahlburg, H.F., et al., *Syndrome-Related Stigma in the General Social Environment as Reported by Women with Classical Congenital Adrenal Hyperplasia*. Arch Sex Behav, 2017. **46**(2): p. 341-351.
64. Meyer-Bahlburg, H.F., et al., *Stigma in Medical Settings As Reported Retrospectively by Women With Congenital Adrenal Hyperplasia (CAH) for Their Childhood and Adolescence*. J Pediatr Psychol, 2016. **2015**: p. 1-8.
65. Falhammar, H., et al., *Health status in 1040 adults with disorders of sex development (DSD): a European multicenter study*. Endocr Connect, 2018. **7**(3): p. 466-478.
66. Johannsen, T.H., et al., *Quality of life in 70 women with disorders of sex development*. Eur J Endocrinol, 2006. **155**(6): p. 877-85.
67. Liang, H., et al., *Psychiatric manifestations in young females with congenital adrenal hyperplasia in Taiwan*. Chang Gung Med, 2008(31): p. 66-73.
68. Bachelot, A., et al., *Determining clinical and biological indicators for health outcomes in adult patients with childhood onset of congenital adrenal hyperplasia*. Eur J Endocrinol, 2015. **173**(2): p. 175-84.
69. Nordenström, A., et al., *Sexual function and surgical outcome in women with congenital adrenal hyperplasia due to CYP21A2 deficiency: clinical perspective and the patients' perception*. J Clin Endocrinol Metab, 2010. **95**(8): p. 3633-40.
70. Bennecke, E., et al., *Health-related quality of life and psychological well-being in adults with differences/disorders of sex development*. Clin Endocrinol (Oxf), 2016. **86**: p. 634-643.
71. Frisen, L., et al., *Gender role behavior, sexuality, and psychosocial adaptation in women with congenital adrenal hyperplasia due to CYP21A2 deficiency*. J Clin Endocrinol Metab, 2009. **94**(9): p. 3432-9.
72. Baratz, A. and K. Karkazis, *Cris de Coeur and the Moral Imperative to Listen to and Learn from Intersex People*. Narrat Inq Bioeth, 2015. **5**(2): p. 127-32.

73. Schweizer, K., et al., *Coping With Diverse Sex Development: Treatment Experiences and Psychosocial Support During Childhood and Adolescence and Adult Well-Being*. J Pediatr Psychol, 2016: p. 1-16.
74. Dwyer, A., Quinton, R, Morin Q, and Pitteloud, N, *Identifying the unmet needs of patients with idiopathic hypothalamic hypogonadism: using a web-based needs assessment: implications for online interventions and peer-to-peer support*. Orphanet J Rare Dis, 2014. **8**(83): p. 1-11.
75. Streuli, J.C., et al., *Shaping parents: impact of contrasting professional counseling on parents' decision making for children with disorders of sex development*. J Sex Med, 2013. **10**(8): p. 1953-60.
76. Earp, B.D. and R. Steinfeld, *Genital Autonomy and Sexual Well-being*. Current Sexual Health Reports, 2018. **10**(1): p. 7-17.
77. Wisniewski, A.B., *Psychosocial implications of disorders of sex development treatment for parents*. Curr Opin Urol, 2017. **27**(1): p. 11-13.
78. Ellens, R.E., et al., *Psychological adjustment in parents of children born with atypical genitalia one year after their child undergoes genitoplasty*. J Urol, 2017. **19**(4): p. 914-20.
79. Suorsa, K.I., et al., *Characterizing Early Psychosocial Functioning of Parents of Children with Moderate to Severe Genital Ambiguity due to Disorders of Sex Development*. J Urol, 2015. **194**(6): p. 1737-42.
80. Roen, K. and P. Hegarty, *Shaping parents, shaping penises: How medical teams frame parents' decisions in response to hypospadias*. Br J Health Psychol, 2018. DOI 10.1111/bjhp.12333.
81. Herman, J.L., et al. *Age of individuals who identify as transgender in the United States*. 2017. Available from: (<http://williamsinstitute.law.ucla.edu/wp-content/uploads/TransAgeReport.pdf>).
82. Liao, L.M., et al., *Determinant factors of gender identity: a commentary*. J Pediatr Urol, 2012. **8**(6): p. 597-601.
83. Pasterski, V., et al., *Increased Cross-Gender Identification Independent of Gender Role Behavior in Girls with Congenital Adrenal Hyperplasia: Results from a Standardized Assessment of 4- to 11-Year-Old Children*. Arch Sex Behav, 2015. **44**(5): p. 1363-75.
84. Dessens, A.B., F.M. Slijper, and S.L. Drop, *Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia*. Arch Sex Behav, 2005. **34**(4): p. 389-97.
85. Kreukels, B.P.C., et al., *Gender Dysphoria and Gender Change in Disorders of Sex Development/Intersex Conditions: Results From the dsd-LIFE Study*. J Sex Med, 2018. **15**(5): p. 777-785.
86. Schweizer, K., et al., *Gender experience and satisfaction with gender allocation in adults with diverse intersex conditions (divergences of sex development, DSD)*. Psychology & Sexuality, 2013. **5**(1): p. 56-82.
87. Lean, W.L., et al., *Cosmetic and anatomic outcomes after feminizing surgery for ambiguous genitalia*. J Pediatr Surg, 2005. **40**(12): p. 1856-60.
88. Baskin, L.S., et al., *Anatomic studies of the human clitoris*. J Urol, 1999. **162**: p. 1015-1020.
89. Baskin, L.S., *Fetal genital anatomy reconstructive implications*. J Urol, 1999. **162**: p. 527-529.
90. Baskin, L.S., et al., *A Neuroanatomical Comparison of Humans and Spotted Hyena, a Natural Animal Model for Common Urogenital Sinus: Clinical Reflections on Feminizing Genitoplasty*. The Journal of Urology, 2006. **175**(1): p. 276-283.
91. Cunha, G.R., et al., *Development of the external genitalia: perspectives from the spotted hyena (Crocuta crocuta)*. Differentiation, 2014. **87**(1-2): p. 4-22.
92. Poppas, D.P., et al., *Nerve sparing ventral clitoroplasty preserves dorsal nerves in congenital adrenal hyperplasia*. J Urol, 2007. **178**(4 Pt 2): p. 1802-6; discussion 1806.
93. Yang, J., D. Felsen, and D.P. Poppas, *Nerve sparing ventral clitoroplasty: analysis of clitoral sensitivity and viability*. J Urol, 2007. **178**(4 Pt 2): p. 1598-601.
94. Dreger, A. and E.K. Feder. *Bad vibrations*. Clinical Trials and Human Subjects Research, Health and Health Care [Bioethics forum] 2010; Available from: (<https://www.thehastingscenter.org/bad-vibrations/>).
95. Tamar-Mattis, A. *OHRP letter*. Advocates for Informed Choice 2010 [cited 2018 9/7]; Available from: (<https://aiclegal.files.wordpress.com/2009/12/ohrp-letter-7-10.pdf>).
96. Dreger, A.D. *The cutting and the vibrators continue*. Alice Domurat Dreger blog 2015 [cited 2018 9/7]; Available from: (<http://alicedreger.com/cutting>).
97. Szymanski, K.M., et al., *Parental decisional regret and views about optimal timing of female genital restoration surgery in congenital adrenal hyperplasia*. J Pediatr Urol, 2017: p. 1.e1-1.e7.

98. Douglas, G., et al., *Consensus in Guidelines for Evaluation of DSD by the Texas Children's Hospital Multidisciplinary Gender Medicine Team*. Int J Pediatr Endocrinol, 2010. **2010**: p. 17.
99. ACOG Opinion on Breast and Labial Surgery in Adolescents. Committee Opinion. 1/2017. [cited 3/22/2018; Available from: <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Breast-and-Labial-Surgery-in-Adolescents - 4a>.
100. Pippi Salle, J.L., et al., *Corporeal sparing dismembered clitoroplasty: an alternative technique for feminizing genitoplasty*. J Urol, 2007. **178**(4 Pt 2): p. 1796-800; discussion 1801.
101. Baratz, A.B. and E.K. Feder, *Misrepresentation of evidence favoring early normalizing surgery for atypical sex anatomies*. Arch Sex Behav, 2015. **44**.
102. Meyer-Bahlburg, H.F.L., *Psychoendocrinology of Congenital Adrenal Hyperplasia*, in *Genetic Steroid Disorders*, M. New, et al., Editors. 2014, Elsevier: Boston. p. 285-300.
103. Meyer-Bahlburg, H.F., et al., *Attitudes of adult 46, XY intersex persons to clinical management policies*. J Urol, 2004. **171**(4): p. 1615-9; discussion 1619.
104. Binet, A., et al., *Should we question early feminizing genitoplasty for patients with congenital adrenal hyperplasia and XX karyotype?* J Pediatr Surg, 2016. **51**(3): p. 465-8.
105. *Consensus statement on 21-hydroxylase deficiency from the Lawson Wilkins Pediatric Endocrine Society and the European Society for Paediatric Endocrinology*. J Clin Endocrinol Metab, 2002. **87**(9): p. 4048-53.
106. Nabhan, Z.M., R.C. Rink, and E.A. Eugster, *Urinary tract infections in children with congenital adrenal hyperplasia*. J Ped Endocrinol Metab, 2006. **19**: p. 815-820.

Appendix A

Arlene B. Baratz MD

Curriculum Vitae

Personal

Home: 1355 Oak Ledge Ct Pittsburgh PS 15241

Cell phone: 412 260 0830

Work: Dept. of Radiology Allegheny General Hospital 312 E. North Ave Pittsburgh PA 15212

Work phone: 412 359 8106

Position/Title

Attending physician Department of Radiology, Division of Breast Imaging

Allegheny Health Network

Temple University School of Medicine

Pittsburgh PA

Coordinator of Medical and Research Affairs:

Androgen Insensitivity Syndrome- Differences of Sex Development (AIS-DSD) Support
Group (<http://aisdsd.org/>)

Chair of Medical and Research Policy Committee:

InterACT- Advocates for Intersex Youth
(<http://interactadvocates.org>)

Education/Training

Institution and Location	Degree	Year	Field of Study
Bryn Mawr College, Bryn Mawr, PA	AB	1976-80	Biology, History of Science
University of Pittsburgh School of Medicine Pittsburgh, PA	MD	1980-84	Medicine
University of Pittsburgh Medical Center Magee- Womens Hospital	Internship	1984-85	Obstetrics/gynecology

University of Pittsburgh Medical Center	Residency	1985-86	Anatomic pathology
University of Pittsburgh Medical Center	Residency	1986-90	Diagnostic radiology

Employment

Attending physician. Women's imaging radiologist. Fogel and Weinstein Imaging. Pittsburgh, PA. 1990-1991.

Attending physician. Associate professor. University of Pittsburgh Department of Radiology. Breast Imaging Division. 1991-97.

Attending physician. Shadyside Hospital. Pittsburgh PA. Department of Radiology. Breast Imaging Division. 1997-2001.

Attending physician. Allegheny Health Network. Pittsburgh PA. Department of Radiology. Breast Imaging Division. 2001-present.

Other Experience and Professional Membership

Global DSD Update Group. Co-chair: Peer Support Committee. Supported by Pediatric Endocrine Society. Organizers: Lee PA, Nordenström, A, Houk, C. 2014-2016.

Androgen Insensitivity Syndrome-Differences of Sex Development (AIS-DSD) Support Group

Coordinator of Medical and Research Affairs 2015-present.

Board of directors 2008-2015.

Medical adviser 2001-present.

InterACT Advocates for Intersex Youth

Chair of Medical and Research Policy Committee 2015-present.

Medical adviser 2007-present.

Board of directors 2007- present.

Founding member 2007.

American Urological Association (AUA) member. 2016.

AIS-DSD Parents Group. Moderator: 2002-2015.

Adviser. Short-term outcomes of interventions for reproductive dysfunction. NIH 1R01HD074579-01A1. Principal investigators: Wisniewski, AB and Mullins, LL. 2013- 2016.

Advocacy Advisory Network. Disorders of Sex Development: Platform for Basic and Translational Research. NIH 5R01HD068138-05. Principal investigators: Vilain EJ and Sandberg DE. 2011-2015.

Pittsburgh Youth and Young Adult Gender and Sexual Development Network. 2012-present.

dsdFamilies.org. An information and support resource for families with children, teens and young adults who have a DSD. Contributor and adviser since 2011.

Advocacy/ Education committee chair. Guidelines for the Development of Comprehensive Care Centers for Congenital Adrenal Hyperplasia: Guidance from the CARES Foundation Initiative. Organizers: Auchus, R, Witchel, S, and Congenital Adrenal Hyperplasia Education, Support, and Research (CARES) Foundation. 2010-2011.

North American Society for Pediatric and Adolescent Gynecology (NASPAG) member 2010-present

Children's Hospital of Pittsburgh DSD committee 2008-present

Accord Alliance Founding member 2007

Society of Breast Imaging 1991-present

Honors

2016. AIS-DSD Support Group Honorary Life Member Award: to honor a member who has made a significant impact on another individuals or group of individuals specifically in the AIS-DSD Support Group.

2016. Arlene Baratz Scholarship Fund established in my honor by AIS-DSD Support Group.

1989-1990. University of Pittsburgh Medical Center chief resident in diagnostic radiology.

Publications (for the last 7 years)

Disorders of Sex Development/Intersex: Gaps in Psychosocial Care for Children.

Ernst MM, Liao LM, Baratz AB, Sandberg DE. Pediatrics. 2018 Aug;142(2). pii: e20174045. doi: 10.1542/peds.2017-4045. No abstract available. PMID:30045929

Identifying and Counting Individuals with Differences of Sex Development Conditions in Population Health Research. Tamar-Mattis S, Gamarel KE, Kantor A, **Baratz A**, Tamar-Mattis A, Operario D. LGBT Health. 2018 Jul;5(5):320-324. doi: 10.1089/lgbt.2017.0180. PMID:29979641

The Ethics of Fertility Preservation for Pediatric Patients with Differences (Disorders) of Sex Development.

Campo-Engelstein L, Chen D, Baratz AB, Johnson EK, Finlayson C. J Endocr Soc. 2017 Jun 1;1(6):638-645. doi: 10.1210/js.2017-00110. PMID: 28944319

Interdisciplinary care in disorders/differences of sex development (DSD): The psychosocial component of the DSD-Translational research network. Sandberg DE¹, Gardner M¹, Callens N^{1,2}, Mazur T³; DSD-TRN

Psychosocial Workgroup, the DSD-TRN Advocacy Advisory Network, and Accord Alliance. Am J Med Genet C Semin Med Genet. 2017 Jun;175(2):279-292. doi: 10.1002/ajmg.c.31561. Epub 2017 Jun 2. PMID: 28574671

Disorders of sex development (DSD): Clinical service delivery in the United States. Rolston AM, Gardner M, van Leeuwen K, Mohnach L, Keegan C, Délot E, Vilain E, Sandberg DE; members of the DSD-TRN Advocacy Advisory Network; Accord Alliance. Am J Med Genet C Semin Med Genet. 2017 Jun;175(2):268-278. doi: 10.1002/ajmg.c.31558. Epub 2017 May 30. PMID: 28557237

Ethical Controversy About Hysterectomy for a Minor. Burgart AM, Strickland J, Davis D, Baratz AB, Karkazis K, Lantos JD. Pediatrics. 2017 Jun;139(6). pii: e20163992. doi: 10.1542/peds.2016-3992. Epub 2017 May 12. PMID: 28562274

Response to 'Re. Attitudes towards disorders of sex development nomenclature among affected individuals'. Johnson EK, Rosoklija I, Finlayson C, Chen D, Yerkes EB, Madonna MB, Holl JL, Baratz AB, Davis G, Cheng EY. J Pediatr Urol. 2017 Dec;13(6):610-611. doi: 10.1016/j.jpuro.2017.04.007. Epub 2017 May 6. No abstract available. PMID: 28552319

Attitudes towards "disorders of sex development" nomenclature among affected individuals. Johnson EK, Rosoklija I, Finlayson C, Chen D, Yerkes EB, Madonna MB, Holl JL, Baratz AB, Davis G, Cheng EY. J Pediatr Urol. 2017 Dec;13(6):608.e1-608.e8. doi: 10.1016/j.jpuro.2017.03.035. Epub 2017 May 8. PMID: 28545802

Re: "Surgery in disorders of sex development (DSD) with a gender issue: If (why), when, and how?" Baratz AB. J Pediatr Urol. 2016 Dec;12(6):442-443. doi: 10.1016/j.jpuro.2016.07.013. Epub 2016 Sep 14. No abstract available. PMID: 27697469

Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care. Lee PA, Nordenström A, Houk CP, Ahmed SF, Auchus R, **Baratz A**, Baratz Dalke K, Liao LM, Lin-Su K, Looijenga LH 3rd, Mazur T, Meyer-Bahlburg HF, Mouriquand P, Quigley CA, Sandberg DE, Vilain E, Witchel S; Global DSD Update Consortium. Horm Res Paediatr. 2016;85(3):158-80. doi: 10.1159/000442975. Epub 2016 Jan 28. Review. Erratum in: Horm Res Paediatr. 2016;85(3):180. Koopman, Peter [added]. PMID: 26820577

The need for support and education for parents of children with reproductive differences. **Baratz A**. BMJ. 2015 Oct 27;351:h5717. doi: 10.1136/bmj.h5717. No abstract available. PMID: 26508123

Cris de Coeur and the Moral Imperative to Listen to and Learn from Intersex People. **Baratz A**, Karkazis K. Narrat Inq Bioeth. 2015 Summer;5(2):127-32. doi: 10.1353/nib.2015.0030. PMID: 26300144

Misrepresentation of evidence favoring early normalizing surgery for atypical sex anatomies. Baratz AB, Feder EK. Arch Sex Behav. 2015 Oct;44(7):1761-3. doi: 10.1007/s10508-015-0529-x. No abstract available. PMID: 25808721

Disorders of sex development peer support. Baratz AB, Sharp MK, Sandberg DE. Endocr Dev. 2014;27:99-112. doi: 10.1159/000363634. Epub 2014 Sep 9. Review. PMID: 25247648

Emotionally and cognitively informed consent for clinical care for differences of sex development. Tamar-Mattis A, Baratz A, Baratz Dalke K, Karkazis K. Psychology & Sexuality. 2013;5(1):44-55. doi:

10.1080/19419899.2013.831215.

Guidelines for the Development of Comprehensive Care Centers for Congenital Adrenal Hyperplasia:

Guidance from the CARES Foundation Initiative. Auchus RJ, Witchel SF, Leight KR, Aisenberg J, Azziz R, Bachega TA, Baker LA, Baratz AB, Baskin LS, Berenbaum SA, Breault DT, Cerame BI, Conway GS, Eugster EA, Fracassa S, Gearhart JP, Geffner ME, Harris KB, Hurwitz RS, Katz AL, Kalro BN, Lee PA, Alger Lin G, Loechner KJ, Marshall I, Merke DP, Migeon CJ, Miller WL, Nenadovich TL, Oberfield SE, Pass KA, Poppas DP, Lloyd-Puryear MA, Quigley CA, Riepe FG, Rink RC, Rivkees SA, Sandberg DE, Schaeffer TL, Schluskel RN, Schneck FX, Seely EW, Snyder D, Speiser PW, Therrell BL, Vanryzin C, Vogiatzi MG, Wajnrajch MP, White PC, Zuckerman AE. Int J Pediatr Endocrinol. 2010;2010:275213. doi: 10.1155/2010/275213. Epub 2011 Jan 10. PMID: 21274448

Re: Editorial: It is (sort of) a boy and (sort of) a girl. You have (sort of) a say and you (sort of) don't? The uneasiness of genital restoration surgery [JPED 2006(11); 19: 1285-1289].

Baratz AB. J Pediatr Endocrinol Metab. 2007 Apr;20(4):551-2. No abstract available. PMID: 17550221

Sex determination, differentiation, and identity. Baratz AB. N Engl J Med. 2004 May 20;350(21):2204-6; author reply 2204-6. No abstract available. PMID: 15156588

Computed radiography versus screen-film mammography in detection of simulated microcalcifications: a receiver operating characteristic study based on phantom images.

Shaw CC, Wang T, King JL, Breitenstein DS, Chang TS, Harris KM, Baratz AB, Ganott MA, Reginella R, Sumkin JH, Gur D. Acad Radiol. 1998 Mar;5(3):173-80. PMID: 9522883

Carcinoma mimicked by the sternal insertion of the pectoral muscle. Britton CA, Baratz AB, Harris KM. AJR

Am J Roentgenol. 1989 Nov;153(5):955-6. PMID: 2801443

The mammographic features of the postlumpectomy, postirradiation breast. Harris KM, Costa-Greco MA, Baratz AB, Britton CA, Ilkhanipour ZS, Ganott MA. Radiographics. 1989 Mar;9(2):253-68. PMID: 2538867

CME Speaker activities (last 5 years)

July 2018. Caring for Adults with DSD/Intersex Traits. Baratz A, Baratz Dalke K. Baratz A. AIS-DSD Support Group and Lurie Children's Hospital CME program. Chicago IL.

November 2017. Evolving Role of Patient Advocacy in Intersex Care. Baratz A, Wong L, Baratz Dalke K. Gay Lesbian Medical Association meeting. Philadelphia PA.

April 2017. Nothing About Us Without Us. North American Society for Pediatric and Adolescent Gynecology Annual Clinical and Research meeting. Baratz A. Chicago IL.

July 2016. The Long and Winding Road- Past, Present and Future of Intersex Care. Baratz A. AIS-DSD Support Group and Colorado Children's Hospital CME program. Aurora CO.

May 2016. Community and Clinicians Creating Change Together. Baratz A. Society of Pediatric Urology meeting. San Diego CA.

April 2016. Managing Genital Difference in Children with Anesthesia Risks: An Alternative Approach. Baratz A. North American Society for Pediatric and Adolescent Gynecology Annual Clinical and Research Meeting. Toronto, Canada.

June 2015. Helping the "I" in LGBTQI: Resources for People Living with Intersex and Diverse Reproductive Development. Philadelphia Trans Health Conference. Malouf M and Baratz A. Philadelphia PA.

June 2015. Managing Genital Difference in Children with Anesthesia Risks: An Alternative Approach. Baratz A. 5th International DSD (I-DSD) symposium. Ghent, Belgium

June 2015. Decision-Making Checklist: Complete Androgen Insensitivity Syndrome. 5th International Disorders of Sex Development (I-DSD) symposium. Graziano K, Hernandez SJ, Baratz A, Muscarella M. Ghent, Belgium.

September 2014. Adding the "I" to LGBTI: Research Priorities for the NIH LGBTI Initiative. Arlene Baratz and Katharine Baratz Dalke. Gay Lesbian Medical Association meeting. Baltimore MD.

July 2014. Where Have We Been and Where Are We Going? Baratz A. University of California San Francisco Medical Center and AIS-DSD Support Group CME program. San Francisco CA.

June 2014. Gender and differences of sex development (DSD) *what we wish clinicians knew. Baratz A, Malouf M. Philadelphia Trans Health Meeting. Philadelphia PA.

July 2013. Helping Families to Improve Well-being: Goals and Communication. Children's Hospital of Boston, Center for Young Women's Health, Harvard University Medical School Teaching Hospital, *dsd*Families, and AIS-DSD Support Group CME program. Boston MA.

Appendix B

Letter of resignation of AAN from TRN

November 24, 2015

To: NIH Translational Research Network and NIH Research Coordinating Committee for Sexual and Gender Minorities
From: AAN Members
Re: Statement of resignation of some AAN Members from TRN

The original invitation to join the Advocacy Advisory Network (AAN) of the NIH Translational Research Network (TRN) evoked an idealistic vision of patients and clinicians setting aside differences and working together to make life happier and healthier for people living with reproductive difference. Rejoicing at the opportunity to have a voice in major decisions about research and care that affect our community in powerful ways, representatives of multiple peer support and advocacy groups eagerly joined. AAN members include advocates with diverse lived experience, who are affected adults, parents, and children, who are affected by a variety of differences, and who range in life stage from youth to maturity. We bring skills from careers in business, academia, law, social work, conflict resolution, project management, counseling, psychology, genetics, non-profit executive directorship, and medicine. We have decades of combined experience in peer support and leadership. Additionally, for the upcoming Global DSD Update sponsored by Pediatric Endocrine Society, Arlene Baratz is co-chair of the committee on patient perspectives and peer support. Despite our representation of our community and many valuable contributions of expertise and experience since we joined AAN four years ago, we are extremely disappointed that TRN has not lived up to its initial promise.

[Alice Dreger](#) and [Tiger Devore](#) recently announced their resignations from AAN on Alice's blog. We agree with some of their ideas, and would like to clarify our own perspective. AIS-DSD Support Group, Advocates for Informed Choice, and our allies listed below are also withdrawing from AAN because of ongoing miscommunication and lack of meaningful inclusion. At this point, having our names associated with TRN is doing more harm than good because chronic issues with TRN prevent meaningful advocacy input. From its inception, despite our requests, TRN failed to include advocates in the design and goals of the project. Having been denied a presence at the initial meeting of investigators, we hoped that subsequent close involvement in projects could influence the direction of research, but most were already IRB-approved by the time we saw them. Instead of an opportunity to contribute, we have experienced a pattern of misrepresentation in which our involvement and concurrence have been falsely implied. Missed deadlines and absence of key project deliverables also frustrate us.

Let us be clear that our resignation has nothing to do with the TRN clinicians and researchers who devote their lives to caring for and about us. We deeply appreciate your presence at our support group meetings, your availability to our members, and your ability to listen and change. Outside TRN, we are delighted to be involved in ongoing projects whose design and goals reflect successful cooperative relationships. We have found we can be extremely effective in supporting the development of research that meets the needs of our communities when we are involved from the beginning in the design of research goals, when we are able to give input into sensitive language, and when we are engaged to ensure that the specific concerns of this community regarding human research ethics and informed choice are addressed. Examples of successful research we have engaged in include projects on parent experiences with making decisions about genital difference;

how young women living with DSD share health information with peers; and parent experiences with genetic testing. Currently, we are working with TRN clinicians on outside projects investigating language, how medical care is experienced, ways to deliver psychosocial care, and evidence-based best practices in CAIS. We look forward to future opportunities to work with anyone from within or outside TRN who is interested in designing research that is inclusive of community concerns.

Although clinicians may have interacted with Accord Alliance as the designated community representative, we found that indirect transmission was effectively censoring our written and verbal communications. This is disturbing because Accord Alliance was founded in 2006 by Bo Laurent (Cheryl Chase), Katrina Karkazis, Arlene Baratz, and David Sandberg to improve medical care by replacing ISNA's confrontational tactics with a fresh, collaborative approach involving multiple stakeholders. At its closure, ISNA's funds and assets were transferred to Accord Alliance, including the *Handbook for Parents* and *Guidelines for Clinicians*. Accord Alliance hosted a research and quality improvement symposium in 2009, but hasn't sponsored any non-medical events since then, according to its blog. Laurent, Karkazis, and Baratz are no longer involved. Supported in its early days by community donations, Accord Alliance's current major source of funding is the TRN grant, which in turn designates the function of DSD community representative to Accord Alliance. This suggests a major conflict of interest. Reinforcing this impression is TRN's repeated failure to share AAN opinions and concerns about various projects with TRN clinicians for example, serious and widespread AAN concerns that a proposed photography project posed potential harm to pediatric research subjects were not conveyed accurately to clinicians. When the time came to submit that proposal, clinicians were surprised to learn our opinion. Having further misled clinicians to believe that only a minority of AAN members requested further input on the proposal, TRN circumvented its requirement for AAN support with a letter from Accord Alliance implying our approval. It was an embarrassment to all of us that the proposal was withdrawn after AAN protested the deceptive letter.

Similarly, AAN members were extensively involved for four years in writing and editing numerous drafts of educational material for a TRN family decision support tool. However, ever since we insisted recently that families be made aware of major international human rights policies involving DSD treatment, our contributions are mysteriously absent. Despite our repeated requests, a version of the decision support tool omitting human rights education is already being piloted with families. Ethics and common decency suggest that shared decision-making should include informing families that many international human rights organizations have new statements strongly affirming the right of children with diverse sex characteristics to make their own choices about irreversible interventions. The [UN High Commissioner for Human Rights](#) and the [UN Special Rapporteur on Health](#), working closely with Advocates for Informed Choice (AIC), have both endorsed these as basic human rights. DSD/intersex is increasingly prominent on an international landscape in the midst of tectonic shifts. AIC will continue to advocate for an informed consent process requiring family counseling to include discussion of both social and medical controversies. Otherwise, how will children feel later when they discover that their parents made important decisions about irreversible interventions using decision support tools that consciously excluded vital information on children's human rights? Parents have a right to know just how controversial these procedures are before they make irreversible decisions.

Finally, the original TRN grant proposal included individual letters of support from AAN member organizations. In May, we were asked to draft a new letter jointly supporting a proposal to fund

TRN for the next funding cycle. After requesting changes in the grant to provide AAN more direct involvement as a condition of support, we never saw such a letter. The grant was later submitted, leaving us to wonder if the controversy was resolved by submitting a letter from Accord Alliance without our knowledge. If so, another five years of advocate dissatisfaction and AAN misrepresentation of our constituents' concerns are practically guaranteed.

AIS-DSD Support Group's mission is to foster successful stakeholder collaborations that promote community through peer support, informed decision-making, and advances in evidence-based care. You see our passionate commitment in the vibrant community of affected people, clinicians, and allies that we nurture. You see it at meeting we sponsor in partnership with DSD teams around the country. You see when you attend our support group meetings, hear how people experience treatment, and learn about research that matters to patients. Likewise, AIC's mission is to advocate for the legal and human rights of children born with intersex traits. Neither organization, can effectively support or advocate for our constituents through the AAN, and so our consciences dictate that our members must resign.

All of us see how hard you work and how much you care. We know you want to see intersex people thrive as much as we do. The world is already changing because of our mutual dedication. Together, we have the power to transform it and we look forward to further collaborations outside the TRN.

Sincerely,

Arlene B. Baratz, MD
Coordinator of Clinical and Research Affairs AIS-DSD SG
Moderator, AIS-DSD Parents Group
AIC Board of Directors and Medical Adviser

Tiger Devore, PhD
Founding member, past president and vice president, Hypospadias Epistasis Association

Amber Jones
Operations Coordinator, AIS-DSD Support Group Moderator,
AIS-DSD Parents Group
Past member, AIS-DSD SG Board of Directors

Jim Lake
Executive Director, Hypospadias Epispadias Association Lissa

Lissa Moran, MPH

Meg Robertson
AIS-DSD SG Board of Directors
Moderator, AIS-DSD Parents Group

Karen Walsh
AIC board of directors

Kimberly Zieselman, JD
Executive Director, Advocates for Informed Choice AIS-
DSD SG Board of Directors

Executive Director

Dina M. Matos

September 4, 2018

Medical Director

Karen Lin Su, MD

Dir. Finance & Operations

Bea M. Pereira, MS

Program Manager

Karen A. Fountain, MPH

Administrative Assistant

Odaly Roche

Communications/Marketing

Assistant

Wendy Connolly

Board of Trustees

Karen Bogaard

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Katherine Fowler

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Alex Dubois

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Chad Lapp

Immediate Past President

Michele Bacus

Keysha Berry

Carlos DaSilva

Brian Hacker

Shahrazad Jalinous

Rhonda Kraff

Jessica Margolies

Stacey Shackley

Emeritus

Jessica Hall Upchurch

Founders

Kelly and Adam Leight

The Council on Ethical and Judicial Affairs
Attn: Elliott J. Crigger, CEJA Secretary
American Medical Association
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611

Dear Dr. Crigger:

Thank you for the opportunity to comment on the AMA Students proposed guidelines banning surgical procedures on girls with congenital adrenal hyperplasia (CAH). A widespread moratorium on all early surgical intervention for girls with CAH, without consideration for patients' individual needs, is a dangerous proposition for children with a life-threatening medical condition and has the potential to cause permanent undue harm, both physically and psychologically.

CAH is a life-threatening endocrine disorder affecting approximately 1 in 15,000 live births and affects boys and girls in equal numbers. Surgical intervention for female CAH patients born with atypical genitalia is not a decision that is taken lightly by the parents who make it on behalf of their children nor by the expert urologists who perform them. CARES Foundation takes great pride in educating parents and adult patients on making such informed decisions by providing them with the pros and cons of the procedure(s), referring patients to expert surgeons, and connecting families to parents and patients who can offer advice and support. We strongly recommend that these decisions be made in consultation with a multidisciplinary team of experts at CAH centers of excellence.

Surgical intervention is never automatically recommended, nor is it ever imposed upon parents as the anti-surgery activists assert. When parents or patients consult with expert urologists or seek CARES' guidance, they have often already done their independent research and decided to move forward with surgery. On occasions when parents decide to delay surgery, our expert surgeons support that decision, as does CARES Foundation.

Over the last two decades, a standard of care has emerged among a select group of pediatric urologists who are highly-specialized in surgical interventions for CAH patients. Infants born with clear chromosomal and gonadal sex and a discordant anatomy **are not re-assigned** to the opposite gender for ease of reconstruction. Rather, the procedures restore function to the existing anatomy. The reconstruction allows for appropriate voiding and normal reproductive function.

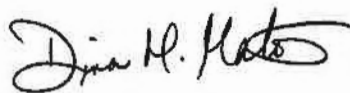
Without surgery, many CAH patients may face incontinence, vaginal reflux and increased risk of infections, which can lead to hospitalizations, life-threatening emergencies, and permanent damage. The vast majority of girls born with CAH identify as female. Forcing them to grow up with a physical appearance that does not match their identity, as proposed by activists, has the potential to cause a lifetime of psychological distress and body dysphoria.

The misguided intent to help these girls with a widespread ban has the potential to be extremely harmful, such as the young child who did not have surgery as an infant and nearly died as a result of an adrenal crisis because she had an internal infection; or the 19 year old who is sitting in a hospital after having surgery (because she didn't have it as an infant) as she is supposed to be starting her sophomore year in college and enjoying life like her friends - something she has not been able to do because of her condition. Parents have stated that the option of early surgery "was necessary for our daughter to have normal urinary function as a child and normal menstrual function as a young woman." An adult patient writes that "surgery has allowed me to have a normal sex life with my husband and I have two beautiful children." Patients' lives and psychologically well-being should not be put at risk to benefit political agendas.

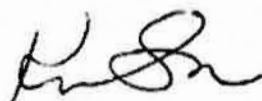
Another important and dangerous consequence of removing the option for surgical intervention and taking away the role of parents in the decision-making process is the detrimental effect it will have on the rights of parents to make medical decisions for their children. Limiting the rights of parents to make medical decisions for their children will negatively impact all pediatric medical care.

We urge you to listen to the voices of patients, families, and medical experts in the field and not be swayed by harmful rhetoric being put forth by those with a political agenda. On behalf of patients and the families of those who live with this condition, we urge you to carefully and critically scrutinize the current proposed moratorium and consider all of its potential negative ramifications.

Sincerely,



Dina M. Matos
Executive Director



Karen Lin Su, MD
Medical Director

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February 2, 2018

Dennis Agliano, MD,
Chair, Council on Ethical and Judicial Affairs
American Medical Association

Dear Dr. Agliano:

It was an honor to address the Reference Committee at the AMA House of Delegates interim meeting in Honolulu last year regarding CEJA report 3, on supporting autonomy for patients with Differences of Sex Development (DSD). As I mentioned during my testimony in the RefCom, Human Rights Watch thanks CEJA for its careful consideration of the ethical elements of care for children with DSD, and we were glad to see our July 2017 report “*I Want To Be Like Nature Made Me*” cited in your report on the matter.

As you may know, we published a second report on intersex/DSD issues in October 2017. This report highlights the voices of providers who care for children with DSD and advise their families. I have attached a copy to this letter for your reference [Appendix 1].

As lead researcher on the project, I interviewed nearly two dozen providers—urologists, psychologists and psychiatrists, gynecologists, endocrinologists, and geneticists—who provide expert care to children and families affected by DSD. In our report, we contextualize the information gathered from the doctors in information we gathered from individuals with DSD and parents of children with DSD, as well as a thorough literature review.

As a public policy analyst, and as someone who is not a doctor, not a parent, and not a person with a DSD, gathering honest, anonymized data and testimony from providers on the front lines of caring for children with

DSD and their families was crucial to developing a nuanced and fact-based perspective on the needed policy changes to protect children, families, and doctors. My co-investigator, Dr. Suegee Tamar-Mattis, brought decades of experience to the matter: she is a practicing physician, a parent, and an intersex person. Human Rights Watch's extensive vetting process, through experts in children's rights, health and human rights, disability, women's rights, law and policy, and outside pediatrician reviewers ensured that our data and recommendations were processed under exacting scrutiny and are of the highest standard.

During the AMA House of Delegates meeting in Hawaii, I met dozens of doctors who were interested in issues surrounding DSD care—from veteran pediatricians to medical students aiming to be OBGYN surgeons. All of these physicians were eager to see the AMA develop coherent policy and standards of care for this vulnerable population.

My time at the HoD reminded me of when Human Rights Watch started our own engagement on intersex/DSD issues. We combed the available medical literature, examined the ethnographic and historical volumes on the topic, and consulted ethicists and healthcare providers with decades of experience. But our most important consideration was that of the community we were engaging with: intersex adults, and parents of children with DSD/intersex traits. It was their experiences we were setting out to document in our report, and it was their experiences we needed to first reflect in our research design.

As I traveled the United States over the course of eight months with Dr. Tamar-Mattis, meeting adults, parents, and providers whose lives had been deeply impacted by DSD, the stories I heard from affected individuals were sometimes overwhelming. The accounts from parents about their feelings of confusion and even coercion to select an irreversible high-risk surgery on their child were striking; the discomfort I heard from doctors involved in the cases—that there were no central guidelines despite decades of data and debates—was bewildering. My own sleepless nights led me to realize that what was lacking in this situation was leadership. There were concerned, compassionate physicians too afraid to speak out about how early unnecessary surgeries were still being conducted in their hospitals; there were intersex adults who spent decades avoiding healthcare, even

in emergencies, because they feared medical professionals; and there were parents who sought nothing other than facts – unadulterated by the gender stereotypes, hubris, or aesthetic preferences of the surgeon they happened to encounter – so they could make the best decisions for their young children.

As CEJA deliberates the ethical issues surrounding care for young patients with DSD, I urge you to consider the following:

Physicians and Parents Alike Need Guidance: As I traveled the country in 2016 and 2017 conducting interviews with parents and physicians, I heard two main themes emerge in their experiences. First, both parents and doctors want to do the best thing possible for their children—both in the immediate sense and for the future; Second, no parent wants to make decisions on hypotheticals or fear, but on facts, and no physician wants to guide parents with anything but the best science. It is in clinical situations such as these where guidance from the AMA is crucial—to protect physicians and parents from making decisions based on fears and not facts, and to protect children from harm and to preserve their open future.

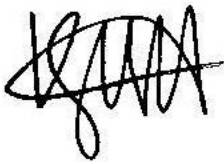
The Parallels with So-Called Gay Conversion Therapy: It was the medical community’s shift in thinking about sexual orientation—that it was a natural variation of human experience and not something in need of treatment—that set the groundwork for important progress on non-discrimination and equal access to quality care in healthcare and society. In the 1990s, medical bodies, including the AMA recognized that there was no evidence that “conversion therapy” delivered on its promise (it did not turn people heterosexual), and ample evidence that it caused harm in the process (it traumatized individuals and furthered anti-LGBT stigma in society). As analyzed by Human Rights Watch, Physicians for Human Rights, dozens of United Nations entities, the World Health Organization, and surgeons-general Dr. Satcher, Dr. Carmona, and Dr. Elders [Appendix 2], medically unnecessary surgeries on children with DSD occupy a similar space at this point in history: There is no evidence that they deliver on their promise of a “normal” life, and there is ample evidence that they carry high risk of negative outcomes. It is time to excise this practice from modern medicine.

The Advances in Medical Support for Transgender Youth: Recent decades have seen medical professionals take significant strides in producing data and

providing affirmative, evidence-based care for transgender and gender non-conforming youth. The AMA's policies in this matter have served as essential guidance for practitioners and policymakers, and supported the health and development of countless young people who need the affirmation of their healthcare providers to survive the violence and discrimination many continue to face in daily life. Modern medicine, including the AMA, has established that trans and gender non-conforming youth need psycho-social support and reversible interventions such as hormone therapies until they are old enough to consent to irreversible surgeries themselves—a paradigm that is supported by transgender advocacy groups, pediatrics bodies, and parent groups alike. A similar approach to youth affected by DSD is supported by medical evidence, medical ethics, current legal frameworks, and intersex community groups. Currently, absent guidance, surgeons around the country who would not countenance genital surgeries on 8-year-old children are conducting similar procedures on 8-month-old children—too young to walk or speak, let alone consent to a sex-assignment operation.

Please do not hesitate to contact me with any questions.

Kind regards,

A handwritten signature in black ink, appearing to read 'Kyle Knight', with a stylized, cursive script.

Kyle Knight
Researcher
Human Rights Watch

CC:

Elliott Crigger, CEJA director, AMA

Craig Johnson, Minority Affairs Section director, AMA



A CHANGING PARADIGM

US Medical Provider Discomfort with Intersex Care Practices

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A Changing Paradigm

US Medical Provider Discomfort with Intersex Care Practices

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A Changing Paradigm

US Medical Provider Discomfort with Intersex Care Practices

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Summary

Historically, when children with atypical sex characteristics were born in the United States, the people around them—parents and doctors—made their best guess and assigned the child a sex. Parents then reared them per social gender norms. Sometimes these people—intersex people—experienced harassment and discrimination as a result of their atypical traits. But many lived well-adjusted lives as adults. During the 1960s, however, based largely on the unproven recommendations of a single prominent psychologist, medical norms in the US changed dramatically. Doctors began recommending surgical solutions to the supposed “problem” of intersex traits—internal sex organs, genitalia, or gonads that do not match typical definitions of male and female. This medical paradigm remains the status quo nearly everywhere in the world today.

Defaulting to surgery resulted in stigmatization, confusion, and fear. In some cases, doctors advised parents to conceal the diagnosis and treatment from the child, instilling feelings of shame in parents and children both. And as a result, many in an entire generation of intersex people did not learn about their conditions until they saw their medical files as adults—sometimes as late as in their 50s.

Over time and with support and pressure from advocates, some medical norms have evolved. Today, intersex children and their families often consult a team of specialists, and not just a surgeon. The medical community has changed its approach to intersex cases—which doctors often categorize as “Differences of Sex Development” or “DSD”—by establishing “DSD teams.” These teams convene multiple healthcare specialists, including mental health providers, to advise on and treat intersex patients. Disclosure of a child’s intersex traits to the child is widely recommended. During this evolution in care, cosmetic surgeries on intersex children’s genitals have become highly controversial within the medical community. However, while the establishment of “DSD teams” has been perhaps the most significant evolution in care and has changed practices considerably, it has not addressed the fundamental human rights issues at stake.

Most medical practitioners now acknowledge that in some cases parents may prefer to leave their child’s body intact as a way of preserving the person’s health, sexual function, fertility options, autonomy, and dignity. Consensus among specialists in intersex health has evolved

to acknowledge data gaps and controversies—namely that there has never been sufficient research to show either that these surgeries benefit patients or that there is any harm from growing up with atypical genitals. A growing number of doctors are opposed to doing unnecessary early surgery under such conditions. Practitioners also increasingly recognize the suffering of intersex patients who underwent the operations without their consent.

However, despite these promising developments in care for intersex people, the field remains fraught with uneven, inadequate, and piecemeal standards of care—and with broad disagreements among practitioners that implicate the human rights of their intersex patients. While there are certain surgical interventions on intersex children that are undisputedly medically necessary, such as the creation of a urinary opening where one does not exist, some surgeons in the US continue to perform medically unnecessary “normalizing” surgeries on children, often before they are one year of age. These operations include clitoral reduction surgeries—procedures that reduce the size of the clitoris for cosmetic reasons. Such surgery carries the risk of chronic pain, nerve damage, and scarring. Other operations include gonadectomies, or the removal of gonads, which result in the child being sterile and forced onto lifelong hormone replacement therapy.

Healthcare providers are an important source of information and comfort amidst confusion. “Clinicians and parents alike refer to the period after the birth of an infant for whom gender assignment is unclear as a ‘nightmare,’” wrote Katrina Karkazis, a medical ethicist at Stanford University. “Not only does a child with ‘no sex’ occupy a legal and social limbo, but surprise, fear, and confusion often rupture the parents’ anticipated joy at the birth of their child.”

An endocrinologist told Human Rights Watch: “I understand the impulse for a parent to create something that looks normal—or at least normal according to a surgeon—at birth before the kid knows anything about it. I follow the logic pattern, but you have to run it against risks.” He said: “It’s important to be clear that a certain percentage of the time, something does go wrong and you have to do a re-op, and there’s a loss of sensitivity. So then the do-no-harm becomes: don’t do anything. What problem were you solving with surgery anyway?”

In July 2017, three former US surgeons-general, including one who was a pediatric endocrinologist, wrote that they believed “there is insufficient evidence that growing up with

atypical genitalia leads to psychosocial distress,” and “while there is little evidence that cosmetic infant genitoplasty is necessary to reduce psychological damage, evidence does show that the surgery itself can cause severe and irreversible physical harm and emotional distress.” They said: “These surgeries violate an individual’s right to personal autonomy over their own future.” The three doctors concluded:

[B]abies are being born who rely on adults to make decisions in their best interest, and this should mean one thing: When an individual is born with atypical genitalia that pose no physical risk, treatment should focus not on surgical intervention but on psychosocial and educational support for the family and child.

For more than 50 years, the medical community in the United States has often defaulted to treating intersex children by conducting irreversible and unnecessary surgeries. Even after two decades of controversy and debate, there remains no research showing that early, medically unnecessary surgery is helpful to the intersex child. Nonetheless, to date, none of the clinics we surveyed have firmly instituted a moratorium on such operations. The evidence is overwhelming that these procedures carry risk of catastrophic harm. And while increasing numbers of doctors believe it is wrong to conduct these procedures, recent data demonstrate that many clinics continue to do so. Alice Dreger, a bioethicist who has written two books on intersex issues and served on a National Institutes of Health multi-site research project before resigning in protest in 2015, wrote of her two decades of engagement on the intersex surgery controversy: “While many clinicians have privately shared my outrage about these activities, in public, the great majority have remained essentially silent.”

International human rights bodies have recognized the practice as implicating and potentially violating a range of fundamental rights, including the rights to health, autonomy, integrity, and freedom from torture. At present, many of the doctors who advise or conduct surgeries on intersex infants and young children cite a lack of data on the outcomes for children who do not undergo surgery. “We just don’t know the consequences of not doing it,” a gynecologist told Human Rights Watch regarding medically unnecessary surgery. Others continue to call for data collection regarding the impact of the intact intersex body on families and society—as if intersex people are a threat to the social order.

For example, a 2015 article co-authored by 30 DSD healthcare providers reflecting on genital surgeries published in the *Journal of Pediatric Urology* stated:

There is general acknowledgement among experts that timing, the choice of the individual and irreversibility of surgical procedures are sources of concerns. There is, however, little evidence provided regarding the impact of non-treated DSD during childhood for the individual development, the parents, society....

Human Rights Watch and interACT believe this approach has it exactly backwards: the experience of those who have undergone the surgery and principles of medical ethics suggest that unless and until there is outcome data establishing that the medical benefits of specific surgical procedures on infants and young children outweigh the potential harms, they should not be used.

Doctors have said they are seeking guidance on the issue so that they can avoid repeating the mistakes of the past. For example, in 2017, Dr. Ilene Wong, a urologist in Pennsylvania, acknowledged the harm in which she took part when she conducted surgery on an intersex child without her consent. She wrote: “Eight years ago, I did irrevocable damage to the first intersex person I ever met.” She said:

While some would argue that surgical practice has improved in the past decades, the fact remains that few attempts have been made to assess the long-term outcomes of these interventions. The psychological damage caused by intervention is just as staggering, as evidenced by generations of intersex adults dealing with post-traumatic stress disorder, problems with intimacy and severe depression. Some were even surgically assigned a gender at birth, only to grow up identifying with the opposite gender.

Others have offered similar testimony. Dr. Deanna Adkins, the Director of the Duke University Center for Child and Adolescent Gender Care, made an expert declaration to oppose North Carolina’s HB2, a sweeping statewide law repealing non-discrimination ordinances protecting lesbian, gay, bisexual, and transgender (LGBT) people and barring transgender people from shared facilities. In her statement, referring to intersex children, Dr. Adkins argued:

It is harmful to make sex assignments based on characteristics other than gender identity. For example, in cases where surgery was done prior to the ability of the child to understand and express their gender identity, there has been significant distress in these individuals who then have to endure further surgeries to reverse the earlier treatments. It has become standard practice to wait until the gender identity is clear to make permanent surgical changes in these patients unless the changes are required to maintain the life or health of the child.

An endocrinologist on a DSD team told Human Rights Watch: “That’s an adage in medicine—above all do no harm.” He added: “I don’t think you’re going to find anybody that runs a DSD clinic that would argue with the fact that outcomes are better when you delay intervention in general.” A DSD specialist Human Rights Watch interviewed argued that “there’s probably rare if any situations where surgery is absolutely necessary.” She said doctors needed “clear guidelines, clear practice standards”—what she called “general principles of care and make it very clear that the emerging data is in favor of not intervening.”

Such guidelines have begun to emerge. In 2016, the American Medical Association Board of Trustees issued a report recognizing that “DSD communities and a growing number of health care professionals have condemned...genital ‘normalizing,’ arguing that except in the rare cases in which DSD presents as life-threatening anomalies, genital modification should be postponed until the patient can meaningfully participate in decision making.” The board recommended adoption of a resolution that, “except when life-threatening circumstances require emergency intervention, [doctors should] defer medical or surgical intervention until the child is able to participate in decision making.”

Accordingly, Human Rights Watch and interACT are urging the AMA, the American Academy of Pediatrics, and other medical bodies, in line with the oath to “Do No Harm,” to support a moratorium on all surgical procedures that seek to alter the gonads, genitals, or internal sex organs of children with atypical sex characteristics too young to participate in the decision, when those procedures both carry a meaningful risk of harm and can be safely deferred.

Methodology

A Note on Terminology

In an effort to be inclusive, accurate, and efficient, this report uses “intersex” to describe people with anatomies that are considered “atypical” for either male or female bodies.

Human Rights Watch and interACT recognize and respect that some people may feel alienated by this definition, some people may disagree with the definition, or some people may object to the use of labels to describe their identities, conditions, or experiences. During each interview, researchers asked interviewees to explain which terms they preferred and identified with. In cases where Human Rights Watch interviewed individuals who specifically rejected the label of “intersex” either for themselves or for their children, we have referred to them using their preferred terminology in this report.

Throughout this report, we reference “medically unnecessary intersex surgeries.” By this we mean: All surgical procedures that seek to alter the gonads, genitals, or internal sex organs of children with atypical sex characteristics too young to participate in the decision, when those procedures both carry a meaningful risk of harm and can be safely deferred.

This report draws heavily on and includes excerpts from the July 25, 2017 report by interACT and Human Rights Watch titled *“I Want to Be Like Nature Made Me”: Medically Unnecessary Surgeries on Intersex Children in the US*. Whereas that previous report examined the experiences of intersex adults, parents of children with intersex traits, and medical practitioners who work on intersex cases, this report focuses largely on the role of medical practitioners and changing medical views of intersex issues. In preparing the current report, we interviewed additional medical practitioners and consulted additional secondary sources, such as recently-published peer-reviewed medical journal articles, relevant to the medical paradigms under consideration.

A Human Rights Watch researcher and a research consultant who is a practicing physician in California conducted the interviews cited in this report. In all, we conducted in-depth interviews with 30 intersex adults, 2 intersex children, 17 parents of intersex children, 21

and healthcare practitioners, including gynecologists, endocrinologists, urologists, psychologists, and other mental health providers who work with intersex people.

In the course of this research, Human Rights Watch wrote letters requesting interviews to 218 relevant health practitioners—either because they were publicly affiliated with a DSD team (a team of specialist healthcare providers who treat patients with intersex traits, or as they are sometimes called in medicine, differences of sex development—“DSD”), or because their name appeared on a published article about intersex medical care. Letters were sent by mail, and followed up by email (see Appendices I and II). In some cases, Human Rights Watch called specific practitioners’ offices to follow up. We interviewed all practitioners who responded to our request; in addition, we interviewed some practitioners who came recommended by other practitioners we had interviewed. Two months after sending the initial letter, Human Rights Watch sent a follow-up letter by mail and email to all practitioners who had not responded to our original request for an interview. We received several written responses declining to be interviewed. All references to practitioners or researchers relevant to intersex medical care that are cited by name are derived from published articles and statements.

In both the initial letter and the follow-up letter to healthcare practitioners, Human Rights Watch explained that we sought a wide range of views. Understanding that providers would not be able to share patient contact information with us, we requested that providers invite their patients and networks to participate in our research. We specifically mentioned that we were eager to interview people who had undergone early surgical interventions and were pleased with the outcomes. Approximately half of the providers we interviewed said they would invite their patients to participate. We received one response based on this request.

All interviews contained a discussion and agreement on informed consent, and interviewees were informed of how the information they shared would be used in Human Rights Watch publications and advocacy. All interviewees are represented only by pseudonyms; in the cases of healthcare providers, they are represented only by their specialty. Neither the names of doctors nor their institutions are mentioned anywhere in the report.

Background

Today, intersex children and their families often consult a team of specialists, and not just a surgeon. The medical community has evolved in its approach to intersex cases—which doctors often categorize as “Differences of Sex Development” or “DSD”—by establishing “DSD teams.” These teams convene multiple healthcare specialists, including mental health providers, to advise on and treat intersex patients. Disclosure of a child’s intersex traits to the child is widely recommended and commonly undertaken. During this evolution in care, cosmetic surgeries on intersex children’s genitals have become highly controversial within the medical community.

Most medical practitioners now acknowledge that in some cases parents may prefer to leave their child’s body intact as a way of preserving the person’s health, sexual function, fertility options, autonomy, and dignity. Consensus among specialists in intersex health has evolved to acknowledge data gaps and controversies—namely that there has never been sufficient research to show either that these surgeries benefit patients or that there is any harm from growing up with atypical genitals. A growing number of doctors are opposed to doing unnecessary early surgery under such conditions. Practitioners also increasingly recognize the suffering of intersex patients who underwent the operations without their consent.

However, despite these promising developments in care for intersex people, the field remains fraught with uneven, inadequate, and piecemeal standards of care—and broad disagreements among practitioners that implicate the human rights of their intersex patients. While there are certain surgical interventions on intersex children that are undisputedly medically necessary, such as operations to repair bladder exstrophy, some surgeons in the US continue to perform medically unnecessary, cosmetic surgeries on children, often before they are one year of age.

A practitioner told Human Rights Watch: “We’re listening to the adult patients who are telling us that they feel they were mistreated and mutilated and that’s a very powerful thing.” She said, “When somebody tells you what they went through at the hands of well-intentioned physicians and they feel like their rights were not respected, you can’t just

blow that off.”¹ Another practitioner said: “And a lot of advocacy work from patients to speak with the physicians at medical conferences and talk about their experience just made a huge difference—I think that's certainly a big part of where I learned about it and got a better understanding of what the outcomes are really like and what the repercussions are for the patients as adults. You know, because as a pediatrician, it's hard to know what happened to them 25 years down the road.”²

The impact has been tangible for some practitioners. An endocrinologist explained: “Many years ago, we thought we were doing the best thing for these patients. And then we started listening to the patients themselves.” Now, he said, “We've evolved our approach. We used to think that we had to make a decision immediately. We know that that's not the case and there's time for families to sort this out.”³

Doctors and researchers in recent years have increasingly spoken out against medically unnecessary non-consensual surgeries on intersex children. For example, in a 2017 article published in the *Journal of Pediatric and Adolescent Gynecology*, Wiebren Tjalma, a surgeon in Belgium, documented a case of genital surgery on an adult woman with Congenital Adrenal Hyperplasia (CAH). Dr. Tjalma argued that “Genital correction surgery for CAH at an older age was easier, could be done in 1 step, and enabled the preservation of orgasm.”⁴ Her results were challenged by two other doctors in a letter to the editor, in which they asserted that the surgeries should be conducted much earlier in an effort to prevent discomfort.⁵ In a response letter, Tjalma explains: “Current practice is like a ritual and not on the basis of any evidence. Dare to change your thoughts about the preservation of erectile bodies. Women should not have mutilating surgery if there is no evidence. The quality of our sex life is important.”⁶

¹ Human Rights Watch interview with a gynecologist, March 7, 2017.

² Human Rights Watch interview with an endocrinologist, February 27, 2017.

³ Human Rights Watch interview with an endocrinologist, February 1, 2017.

⁴ Wiebren A.A. Tjalma, “Assembling a Functional Clitoris and Vulva from a Pseudo-Penis: A Surgical Technique for an Adult Woman with Congenital Adrenal Hyperplasia.” *Journal of Pediatric and Adolescent Gynecology*. Vol. 30(3) (2017), pp. 425–428.

⁵ Hisham A and Mat Zain MA, “Letter to the Editor Regarding Article, ‘Assembling a Functional Clitoris and Vulva from a Pseudo-Penis: A Surgical Technique for an Adult Woman with Congenital Adrenal Hyperplasia’,” *Journal of Pediatric and Adolescent Gynecology* 30(4) (2017):513, doi: 10.1016/j.jpag.2017.02.008.

⁶ Wiebren Tjalma, “The Blessings of Erectile Bodies.” *Journal of Pediatric and Adolescent Gynecology* 30(4) (2017):514-515, [http://www.jpagonline.org/article/S1083-3188\(17\)30262-0/abstract](http://www.jpagonline.org/article/S1083-3188(17)30262-0/abstract).

Going further back, in 2004, a group of researchers and physicians convened by the Hastings Center in New York released an article in which they said “none of the appearance-altering surgeries need to be performed quickly.”⁷ In 2006, a consortium of patient advocates, parents, and medical providers published a set of clinical guidelines that urged “delay [of] elective surgical and hormonal treatments until the patient can actively participate in decision-making about how his or her own body will look, feel, and function,” promoted psychosocial support for families, and offered tools for professionals to support parents without unnecessary surgery.⁸

In 2015, bioethicists and patient advocates affiliated with the Differences of Sex Development-Translational Research Network (DSD-TRN)—a multi-site NIH-funded university research initiative—resigned, citing frustration with the ongoing use of medically unnecessary surgeries on intersex children, use of genital photography of children in research, and, as one medical ethicist put it in her resignation: “Being asked to be a sort of absolving priest of the medical establishment in intersex care.”⁹

The ethicist who wrote that, Alice Dreger, has highlighted that throughout her decades of work and two academic books¹⁰ on intersex issues, “While many clinicians have privately shared my outrage about these activities, in public, the great majority have remained essentially silent.”¹¹

This report attempts to shed light on the private analysis doctors undertake by drawing on anonymized Human Rights Watch interviews with 21 practitioners in 2016 and 2017. Many described increasing discomfort among healthcare providers with the current haphazard and insufficient standards of care for intersex youth, and a desire for clear, centralized guidelines. As demonstrated in the timeline below, medical associations have been gradually adjusting their understanding of the controversy around medically unnecessary

⁷ Joel Frader et. al., “Health Care Professionals and Intersex Conditions,” The Hastings Institute, <http://www.isna.org/pdf/Frader2004.pdf>

⁸ The Consortium on Disorders of Sex Development, “Clinical Guidelines for the Management of Disorders of Sex Development in Childhood and Handbook for Parents,” 2006. www.dsdguidelines.org

⁹ Alice Dreger, “Rejecting the Tranquilizing Drug of Gradualism in Intersex Care.” [Alicedreger.com](http://alicedreger.com/DSD_human_rights), November 21, 2015, http://alicedreger.com/DSD_human_rights.

¹⁰ Alice Domurat Dreger. *Hermaphrodites and the Medical Invention of Sex*. (United States of America: Harvard University Press, 1998); Alice Domurat Dreger. *Intersex in the Age of Ethics*. (Frederick Maryland: University Publishing Group, 1999).

¹¹ Ibid.

surgeries to reflect how their members see it—a set of issues that, while contentious is in clear need of centralized guidance to protect patients from harm.

As Dr. Katie Dalke, a psychiatrist who is also an intersex woman, wrote in a 2017 op-ed:

More than to do no harm, we want to do something *good*. We dedicate ourselves to helping our patients confront and conquer the unthinkable: sickness, pain, and death.

But as an intersex person, I know that “correcting” and concealing intersex bodies causes harm. If our community, including our caregivers and medical-care providers, are to develop standards of care that do good, they must respect bodily diversity. Doctors need to stop trying to avoid harm by trying to fix or hide our bodies and pain.

I know it’s existentially jarring to accept that physicians can be a cause of suffering. Like my peers, when I am on the receiving end of a patient’s anger, I turn to colleagues for support and scour databases to learn what I can do differently. Like my peers, knowing that a patient felt I didn’t do what was best for them lingers in my mind every time I see someone who reminds me of where I went wrong. And like my peers, my helplessness and guilt can make me want to blame or avoid my patient.

And yet, progress cannot occur without validating the anger that patients feel as a direct consequence of their treatment. Some physicians struggle to understand this, insisting that they did what they were taught was right, dismissing intersex people’s pain as non-representative, and telling us we need to not be “angry activists.”

Dr. Dalke urged her fellow healthcare providers to engage with the intersex community, not dismiss their anger:

By listening to and legitimizing the anger and hurt of intersex people, physicians can help us heal. This is absolutely critical to create affirming,

supportive, and transparent treatment models. Ending medically unnecessary non-consensual surgeries is the first step—a necessary change to build trust. Then we can all begin to build a model of care focused on healing.¹²

The Evolution of Medical Understandings and Protocol

1996: The American Academy of Pediatrics (AAP) publishes a statement saying: “The Academy is deeply concerned about the emotional, cognitive, and body image development of intersexuals, and believes that successful early genital surgery minimizes these issues.”¹³

1997: Milton Diamond and Keith Sigmundson publish a paper denouncing early genital surgery on intersex children, based on David Reimer’s outcomes. They write: “We suggest referring the parents and child to appropriate and periodic long-term counseling rather than to immediate surgery and sex reassignment, which seems a simple and immediate solution to a complicated problem.”¹⁴ David Reimer, who was surgically assigned female after a circumcision accident by Dr. John Money at Johns Hopkins, and whose case bolstered the rationale for early genital surgery, publicly renounces Dr. Money’s experiment.¹⁵

1998: The Gay and Lesbian Medical Association (now GLMA: Health Professionals Advancing LGBT Equality) passes a policy resolution calling for research on outcomes of genital-normalizing surgery, and full disclosure of risks and alternatives by physicians to parents of intersex children considering surgery.¹⁶

2000: The AAP issues a statement referring to the birth of an intersex child as “a social emergency” and urging early surgery, while recognizing that “few studies have been done

¹² Katie B. Dalke, “Why Intersex Patients Need the Truth and Doctors Need to Listen,” *The Nation*, September 12, 2017, <https://www.thenation.com/article/why-intersex-patients-need-the-truth-and-doctors-need-to-listen/>

¹³ “American Academy of Pediatrics Position on Intersexuality,” *Intersex Day*, October 15, 2010, <http://intersexday.org/en/aap-position-1996/>

¹⁴ Diamond and Sigmundson, “Sex Reassignment at Birth: Long-term Review and Clinical Implications,” *Archives of Pediatric and Adolescent Medicine*, pp. 298-304.

¹⁵ John Colapinto. “The True Story of John/Joan”. *Rolling Stone*. pp. 54–97.

¹⁶ “GLMA Passes Resolution on Intersex Surgery,” *International Foundation for Gender Education*, March 7, 1998. <http://www.ifge.org/news/1998/march/nws3218b.htm>

that address the social, psychological, and sexual outcomes...”¹⁷

2004: The National Institute of Diabetes & Digestive & Kidney Diseases states: “[t]here is currently a crisis in clinical management of children with disorders of sexual differentiation, and it has received considerable public attention. It stems from two issues. First, for some of these disorders, there are insufficient data to guide the clinician and family in sex assignment. Second, the optimal application of surgery and its timing remain unclear.”¹⁸

2006: The Consensus Statement on the Management of Intersex Disorders acknowledges the lack of meaningful research and calls for further studies, while still allowing for genitoplasty, including clitoral reduction. This statement is adopted as a position statement of the AAP.¹⁹

2010: Thirty-two academicians write to the Office of Human Research Protections (OHRP) and the US Food and Drug Administration (FDA) calling for an investigation into alleged human research violations involving intersex fetuses and children.²⁰

2010: The AAP publishes a position statement opposing all forms of female genital cutting, with no explicit exception for girls with intersex traits.²¹

2011: The National Institutes of Health gives a founding grant to form the DSD Translational Research Network (DSD-TRN) to: “Assess and respond to the specific needs of DSD patients by: developing psychosocial assessment tools specific to the needs of DSD families; developing tools to minimize the need for genital photography; assessing efficacy of and compliance to standards-of-care; discovering new genes causing DSDs.”²²

¹⁷ The American Academy of Pediatrics, “Evaluation of the Newborn with Developmental Anomalies of the External Genitalia,” *Pediatrics* 106(1) (2000), <http://pediatrics.aappublications.org/content/106/1/138>.

¹⁸ The National Institutes of Health, the National Institute of Diabetes & Digestive & Kidney Diseases, *Research Progress Report and Strategic Plan for Pediatric Urology* (2006).

¹⁹ Peter Lee, et. al., “Consensus Statement on Management of Intersex Disorders,” *Pediatrics* 118 (2) (2006): p. 554-563, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2082839/>

²⁰ Alice Dreger et al., “Prenatal Dexamethasone for Congenital Adrenal Hyperplasia: An Ethics Canary in the Modern Medical Mine,” *Journal of Bioethical Inquiry* 9(3) (2012): p.277-294, <https://link.springer.com/article/10.1007%2Fs11673-012-9384-9>

²¹ “Policy Statement—Ritual Genital Cutting of Female Minors,” *American Academy of Pediatrics* 126(1) (2010), <http://pediatrics.aappublications.org/content/pediatrics/126/1/191.full.pdf>.

²² About the Disorders of Sex Development Translational Research Network, <https://dsdtrn.genetics.ucla.edu/aboutdsdtrn>

2011: The World Professional Association for Transgender Health (WPATH) releases revised Standards of Care that include a section calling for careful staging of medical interventions for transgender children and youth, and the delay of irreversible procedures. However, the policy allows for early surgical interventions on intersex children.²³

2012: A paper in the *Journal of Pediatric Urology* concerning the “[t]iming and nature of reconstructive surgery for disorders of sex development” explains “The ideal timing and nature of surgical reconstruction in individuals with...DSD is highly controversial... evidence-based recommendations still cannot be made,” and recognizes that “clitoroplasty is essentially a cosmetic procedure...surgery carries the risk of disruption of the nerve supply of the clitoris.”²⁴

2013: The AAP advocates psychological care prior to any desired gender-affirming surgical intervention in the case of transgender youth, but does not address similar procedures on intersex children too young to express an opinion.²⁵

2013: The World Health Organization publicly opposes early genital or sterilizing surgeries on intersex youth in its report, “Eliminating forced, coercive and otherwise involuntary sterilization.”²⁶

2014: The provisional section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness of the AAP publishes “Explaining Disorders of Sex Development & Intersexuality,” which states: “If it is not medically necessary, any irreversible procedure can be postponed until the child is old enough to agree to the procedure (e.g. genital surgery).”²⁷

2015: Patient advocates and bioethicists publicly resign from the DSD-TRN, citing

²³ The World Professional Association for Transgender Health (WPATH), “Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People Version 7,” http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926

²⁴ Sarah Creighton, et. al., “Timing and nature of reconstructive surgery for disorders of sex development,” *Journal of Pediatric Urology*, 8(6) (2012): 602-610, <http://www.ncbi.nlm.nih.gov/pubmed/23146296>

²⁵ David Levine, et al., “Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth.” *Pediatrics* 132(1) (2013), <http://pediatrics.aappublications.org/content/132/1/e297>

²⁶ United Nations World Health Organization, et. al., “Eliminating Forced, Coercive and Otherwise Involuntary Sterilization—An Interagency Statement,” *World Health Organization*, May 2014.

²⁷ “Explaining Disorders of Sex Development & Intersexuality,” Lesbian, Gay, Bisexual, and Transgender Health and Wellness of the American Academy of Pediatrics, <https://www.healthychildren.org/English/health-issues/conditions/genitourinary-tract/Pages/Explaining-Disorders-of-Sex-Development-Intersexuality.aspx>

frustration with the ongoing use of medically unnecessary surgeries on intersex children, use of genital photography of children in research, and, as one member put it in her resignation: “Being asked to be a sort of absolving priest of the medical establishment in intersex care.”²⁸

2016: The American College of Obstetricians and Gynecologists issues a committee opinion cautioning that genital surgery may not be appropriate for every adolescent with “abnormalities” and that counseling is recommended prior to surgery.²⁹

2016: Physicians publish “Global Disorders of Sex Development Update since 2006,” stating: “[t]here is no evidence regarding the impact of surgically treated or non-treated DSDs during childhood for the individual, the parents, society or the risk of stigmatization...[t]here is still no consensual attitude regarding indications, timing, procedure and evaluation of outcome of DSD surgery.”³⁰

2016: The Gay and Lesbian Medical Association takes an official position recommending delay of all medically unnecessary surgery on intersex children until the child can participate in decisions regarding their body.³¹

2016: The American Medical Association Board of Trustees issues a report recognizing that “DSD communities and a growing number of health care professionals have condemned ... genital ‘normalizing,’ arguing that except in the rare cases in which DSD presents as life-threatening anomalies, genital modification should be postponed until the patient can meaningfully participate in decision making,” and recommending adoption of a resolution supporting treatment that, “except when life-threatening circumstances require emergency

²⁸ See Appendix III for the joint resignation letter. Alice Dreger, “Rejecting the Tranquilizing Drug of Gradualism in Intersex Care.” *Alicedreger.com*, November 21, 2015, http://alicedreger.com/DSD_human_rights.

²⁹ The American College of Obstetricians and Gynecologists, Committee on Adolescent Health Care, “Committee Opinion, Number 686,” January 2017, <https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Breast-and-Labial-Surgery-in-Adolescents>.

³⁰ ³⁰ Peter A. Lee et al., “Global Disorders of Sex Development Update Since 2006: Perceptions, Approach and Care,” *Hormone Research in Pediatrics* 85(3) (2016):158-180, <https://www.ncbi.nlm.nih.gov/pubmed/26820577>

³¹ GLMA, “Medical and Surgical Intervention of Patients with Differences in Sex Development,” October 3, 2016, <http://glma.org/index.cfm?fuseaction=document.viewdocument&ID=CEB9FEE4B8DD8B7F4F7575376BD476C3A433379DD853BEA17913AFCCB8270299C0731320B03D2F5E1022F1C15602FBEA>

intervention, defers medical or surgical intervention until the child is able to participate in decision making.”³²

2016: In its final rule issued for the Affordable Care Act, the Office for Civil Rights (OCR) of the Department of Health and Human Services states that “the prohibition on sex discrimination extends to discrimination on the basis of intersex traits or atypical sex characteristics. OCR intends to apply its definition of ‘on the basis of sex’ to discrimination on these cases.”³³

2017: Three former US surgeons-general issue a statement calling for a moratorium on medically unnecessary surgeries on intersex children too young to participate in the decision, noting that “Those whose oath or conscience says ‘do no harm’ should heed the simple fact that, to date, research does not support the practice of cosmetic infant genitoplasty.”³⁴

³² American Medical Association, “American Medical Association House of Delegates (I-16), Report of Reference Committee on Amendments to Constitution and Bylaws,” 2016, <https://assets.ama-assn.org/sub/meeting/documents/i16-ref-comm-conby.pdf>

³³ Department of Health and Human Services, “Nondiscrimination in Health Programs and Activities; Final Rule. 45 CFR Part 92,” *Final Register* 81(96), May 18, 2016, <https://www.gpo.gov/fdsys/pkg/FR-2016-05-18/pdf/2016-11458.pdf>.

³⁴ Palm Center, “Re-Thinking Genital Surgeries on Intersex Infants,” June 2017, <http://www.palmcenter.org/wp-content/uploads/2017/06/Re-Thinking-Genital-Surgeries-1.pdf>

Anxieties About Social Outcomes Drive Surgery

Nationwide data on how prevalent surgeries are on intersex children do not exist. However, available data sources show that doctors continue to perform medically unnecessary cosmetic surgical procedures on children with atypical sex characteristics in the United States—often before they are one year of age. US government data compiled from several voluntary-reporting databases, for example, show that in 2014—the most recent year for which data are available—clitoral surgery was reported 70 times. Many hospitals do not participate in these databases.³⁵

Other recent medical literature demonstrates that doctors are continuing to conduct medically unnecessary surgeries on intersex children. A 2016 paper in the *Journal of Steroid Biochemistry and Molecular Biology* conducted a literature review of genital surgeries performed on intersex children between 2005 and 2012; the average age was 11.2 months.³⁶ In a 2016 paper published in the *Journal of Pediatric Urology*, doctors examined a cohort of 37 pediatric patients with atypical genitalia from children's hospitals across the country. Of the 37 cases, 35 opted for cosmetic surgery on their children and two did not.³⁷ A 2017 paper in *The Journal of Urology* documented that 25 of 26 intersex babies, whose parents were recruited for the study from 10 DSD centers of excellence across the country, were subjected to genital surgeries.³⁸

While published data show that medically unnecessary surgeries are being conducted on intersex children, practitioners interviewed for this report often reported that they observed

³⁵ This data is compiled from the HCUP National (Nationwide) Inpatient Sample (NIS), the HCUP Kids' Inpatient Database (KID), or the HCUP State Inpatient Databases (SID). United States Department of Health and Human Services, Agency for Healthcare Research and Quality Healthcare Cost and Utilization Project, HCUP-net database, <https://hcupnet-archive.ahrq.gov/> (accessed July 4, 2017).

³⁶ Lily C. Wang and Dix P. Poppas, "Surgical Outcomes and Complications of Reconstructive Surgery in the Female Congenital Adrenal Hyperplasia Patient: What Every Endocrinologist Should Know," *Journal of Steroid Biochemistry and Molecular Biology* 165(Pt A) (2016):137-144, <https://www.ncbi.nlm.nih.gov/pubmed/26995108>. Recently, doctors at a major conference presented information from one registry (which is currently inaccessible to patient groups) confirming the frequency of certain surgeries performed on infants. Regarding initial surgical intervention for children with CAH, they noted: "544 patients underwent feminizing genitoplasty between 2004-2014, median age at initial surgery: 9.9 months."

³⁷ Natalie Nokoff et al., "Prospective Assessment of Cosmesis Before and After Genital Surgery," *Journal of Pediatric Urology* 13(1) (2017): 28.e1 - 28.e6, [http://www.jpurology.com/article/S1477-5131\(16\)30279-0/abstract](http://www.jpurology.com/article/S1477-5131(16)30279-0/abstract).

³⁸ Rebecca Ellens et al., "Psychological Adjustment in Parents of Children Born with Atypical Genitalia One Year After Their Child Undergoes Genitoplasty," *The Journal of Urology*, May 11, 2017, 10.1016/j.juro.2017.05.035.

general trends toward doing fewer surgeries (though they did not always specify which procedures). While some said they insisted on multiple counseling sessions with parents who were considering medically unnecessary surgeries, none of the healthcare providers Human Rights Watch interviewed said their clinic had instituted a moratorium on all medically unnecessary procedures.

Many providers interviewed for this report described the information they shared with parents as based on hypotheticals about what it would be like to raise an intact child, and “clinical expertise,” not data on medical outcomes. This pattern is also reflected in a 2016 update to the 2006 “DSD Consensus Statement,” which includes a survey of 32 experts—mostly surgeons—on guidelines for surgeries. The document notes: “There is still no consensual attitude regarding indications, timing, procedure and evaluation of outcome of DSD surgery. The levels of evidence of responses given by the experts are low, while most are supported by team expertise.”³⁹

Medically unnecessary surgeries persist. For example, in our July 2017 report, we documented a case in which parents were urged to elect surgery on their 11-month-old child in 2010 before they had even received the child’s DSD diagnosis. We also interviewed families who faced intense pressure from doctors to elect medically unnecessary surgeries at major DSD “centers of excellence” in the past three years.

Even after two decades of controversy and debate, there remains no research showing that early, medically unnecessary genital surgery is helpful to the intersex child. Nor is there data to predict gender identity outcomes with confidence in many intersex conditions—meaning that doctors are sometimes conducting sex assignment surgeries that the children will later reject.⁴⁰ As documented in our July 2017 report, this can mean doctors give parents information about gender identity, surgical risks, and the reversibility of certain procedures that have no basis in medical literature.

³⁹ Lee et al., “Global Disorders of Sex Development Update Since 2006: Perceptions, Approach and Care.”

⁴⁰ Peter Lee, et al., “Review of Recent Outcome Data of Disorders of Sex Development (DSD): Emphasis on Surgical and Sexual Outcomes,” *Journal of Pediatric Urology* 8(6) (2012): 611-615 <http://dx.doi.org/10.1016/j.jpuro.2012.10.017>; L-M Liao et al., “Determinant Factors of Gender Identity: A Commentary,” *Journal of Pediatric Urology* 8(6) (2012): 597-601, <http://dx.doi.org/10.1016/j.jpuro.2012.09.009>.

Practitioners Human Rights Watch interviewed recounted the deep concerns parents of intersex children express upon discovery of intersex traits at birth, or referral to their clinic. Some practitioners cited broad parental concerns about how the child would grow up—ranging from gender identity outcomes to fears of homosexuality. For example, a gynecologist explained: “We have families who are very concerned that their child is gender non-conforming or has homosexual attraction— because it’s not OK in their community.”⁴¹ But, she said, the majority of parental concerns are more immediate and practical: “We have families who are terrified of having their daughter’s diaper changed at church or by a babysitter.”⁴²

A urologist who works with a DSD team told Human Rights Watch that parents’ fears about their children’s genitalia often drive the decision to select surgery. “The phrase ‘middle school locker room’ gets tossed around quite a bit,” he said.⁴³ As we found previously some parents who found their way to peer support groups found their fears greatly relieved when they talked to more experienced parents, and learned useful strategies for dealing with the situations they dreaded.⁴⁴

An endocrinologist on a DSD team said the most common fears she hears from parents with children who have atypical external genitalia relate to diaper changes, bathing suits, and, for boys, being able to stand to pee. “A lot of people just will not let anybody else change their child's diaper or put their child in daycare or preschool until they've had surgery,” she said.⁴⁵ This endocrinologist said such families tend to focus on the intersex traits thinking “this is a medical problem, we just need to fix a medical problem,” an observation we heard from other practitioners as well. She explained: “I think that they're very reluctant to acknowledge things beyond the medical side of it. As endocrinologists and psychologists—we’re not reluctant to bring those [non-medical] things up with families. However, I really do think most parents of infants still see surgery as a quick fix option no matter what we say.”

⁴¹ Human Rights Watch interview with a gynecologist, March 7, 2017.

⁴² Human Rights Watch interview with a gynecologist, March 7, 2017.

⁴³ Human Rights Watch interview with a urologist, February 23, 2017.

⁴⁴ Human Rights Watch, *“I Want to Be Like Nature Made Me”: Medically Unnecessary Surgeries on Intersex Children in the US*, July 25, 2017, <https://www.hrw.org/report/2017/07/25/i-want-be-nature-made-me/medically-unnecessary-surgeries-intersex-children-us>

⁴⁵ Human Rights Watch interview with an endocrinologist, February 23, 2017.

A urologist Human Rights Watch interviewed explained that societal expectations were driving the perceived need for clitoral reduction surgeries:

The girl with the big clitoris—do we make it look good before puberty or do we wait? In a perfect world, no of course we'd wait. But it's not a perfect world and parents know that—parents say: look I'd love to live in a place with that kind of body and not get any grief...⁴⁶

Another doctor on a DSD team said: “One of the surgeries that I think makes people very angry is the clitoroplasty, because it’s just an enlarged clitoris and there’s no function that you’re serving by making it smaller—you’re just treating the eye of the beholder.”⁴⁷ Another doctor explained that she understood the persistence of medically unnecessary surgeries in the field as one of inertia and resistance to change: “If this is your career as this is part of your professional identity, if this is a specialty you've become known for, it is very hard to back away from it,” she said. “I think that there are going to be a few doctors...who really built a career on providing normalizing surgeries. It's going to be very hard to back away and say, ‘yeah there's maybe another way maybe a better way to care and support these families.’”⁴⁸

A dearth of data on outcomes for intact children does not support defaulting to conducting irreversible and medically unnecessary surgeries that carry the potential for harm. Indeed, the available medical evidence points overwhelmingly in the opposite direction: that the well-documented harms of these operations should be a primary factor in doctors’ recommendation to defer them until the patient can understand and consent to (or refuse) the procedure. Or, as the former US surgeons-general argued in their 2017 article, “our review of the available evidence has persuaded us that cosmetic infant genitoplasty is not justified absent a need to ensure physical function,” explaining that the belief that surgery can lead to better psycho-social outcomes is based on “untested assumptions rather than medical research.”⁴⁹

⁴⁶ Human Rights Watch interview with a urologist, February 15, 2017.

⁴⁷ Human Rights Watch interview with a gynecologist, February 3, 2017.

⁴⁸ Human Rights Watch interview with a pediatric surgeon, April 28, 2017.

⁴⁹ Palm Center, “Re-Thinking Genital Surgeries on Intersex Infants.”

Doctors, in their clinical conversations with parents, are in a good position to correct these assumptions and put social hypotheticals into better perspective. “The pediatricians are in a position of power. And if it’s an issue of parents being scared, that is the problem that has to get solved. It’s not really a matter of if you do surgery—that doesn’t make any sense, that’s not solving anything,” an endocrinologist told Human Rights Watch. “There are no data that it’s solving anything, and there’s ample evidence that people who underwent the surgery overwhelmingly think that it shouldn’t be done.”⁵⁰ He explained:

The solution to [intersex children] fitting in or not fitting in is not solved by compelling them to do something that is the scientifically wrong thing. An example would be the approach to left-handedness. There was an era not very long ago, similar timeframe, frankly, 50 years ago, where being left-handed was considered not fitting in, whether it be for penmanship or for use of various devices or for athletics and therefore, in order to have your child fit in, your child needed to be right-handed. We went to some great lengths to make that happen. If you ask now, go back to the medical establishment, the medical establishment's role there would be to say, ‘No. Being left-handed is a biological phenomenon. You can't change that. You're going to do more harm forcing people to change. Rather, on the fitting in question, society has to change so that left-handed people are also accepted.’

According to this doctor, “It’s the role of the medical establishment to talk about the science and how we understand the biology actually to be.” He said:

When we're talking about intersex individuals, if we're going to be scientists, it does not make sense for us to suggest that there ought to be procedures in order to fix children to make them fit in, surgical procedures that are going to have negative consequences downstream.⁵¹

⁵⁰ Human Rights Watch interview with an endocrinologist, June 1, 2017.

⁵¹ Human Rights Watch interview with an endocrinologist, June 1, 2017.

Providers Increasingly Hesitant to Recommend Surgery

Some doctors have come out publicly to discuss their involvement in and discomfort with the default-to-surgery paradigm.

For example, Dr. Ilene Wong, a urologist in Pennsylvania, wrote in a 2017 op-ed:

Eight years ago, I did irrevocable damage to the first intersex person I ever met, taking out the gonads of a 17-year-old girl who found out after she never got her period that she had XY chromosomes, with internal testicles instead of ovaries and a uterus.... While some would argue that surgical practice has improved in the past decades, the fact remains that few attempts have been made to assess the long-term outcomes of these interventions. The psychological damage caused by intervention is just as staggering, as evidenced by generations of intersex adults dealing with post-traumatic stress disorder, problems with intimacy and severe depression. Some were even surgically assigned a gender at birth, only to grow up identifying with the opposite gender. The notion of performing an irreversible procedure on a child—one that will likely render her incapable of achieving sexual pleasure in the future—is utterly abhorrent to me, as an insult on the body autonomy of a minor who is, by definition, incapable of giving informed consent.⁵²

Like Dr. Wong, many providers who care for intersex children have become increasingly uncomfortable with the current paradigm. Despite the lack of clear, centralized standards of care for intersex patients, many providers express an increased sense of caution when it comes to recommending medically unnecessary surgeries for children. However, that hesitation has not resulted in comprehensive practice reform. Some doctors continue to recommend and conduct surgeries that are medically unnecessary, high-risk, and without proven benefits.

⁵² I.W. Gregorio, “Should Surgeons Perform Irreversible Genital Surgery on Children?” *Newsweek*, April 26, 2017, <http://www.newsweek.com/should-surgeons-perform-irreversible-genital-surgery-children-589353>.

Doctors Human Rights Watch interviewed at two DSD clinics said that part of their informed consent process with parents of intersex infants who were considering medically unnecessary surgeries was to tell them that United Nations experts and other human rights bodies consider the operations a form of torture. However, doctors at both clinics confirmed that that information did not prevent all parents from opting into the procedures.

Individual providers also explained the increased caution with which they and their colleagues approach medically unnecessary surgeries. For example, a urologist told Human Rights Watch, “I think we're being very cautious about anything that removes tissue.” She said her clinic sets a strict six-month minimum age for medically unnecessary surgeries, which they communicate to parents immediately. “We just explain that we really don't do any elective surgery for babies for six months, period. We reassure them that there is not going to be anything bad that happens to the child waiting for six months.”⁵³ However, this urologist clarified that this has not resulted in a complete end to cosmetic operations on children over six months old: “We're doing very, very few feminizing surgeries in general.... Since I've been here we've only done a few and I've been here three years.”⁵⁴

An endocrinologist on a DSD team said he observes “a general trend of ‘if in doubt don't do anything.’” He said: “We try to emphasize that while we're sorting things out it's best to leave things alone. If there's no urgency from a medical standpoint it's best to leave things as they are and what we have we're finding as time goes on that many of the patients are very comfortable with that.” He linked that to medical ethics: “That's an adage in medicine—above all do no harm.” He added: “I don't think you're going to find anybody that runs a DSD clinic that would argue with the fact that outcomes are better when you delay intervention in general.”⁵⁵

A urologist Human Rights Watch interviewed explained that he sees the emerging skepticism regarding early medically unnecessary surgeries on intersex children as a result of the risks involved. Calling genital surgery “an emotionally charged issue,” he said:

⁵³ Human Rights Watch interview with a urologist, February 6, 2017.

⁵⁴ Human Rights Watch interview with a urologist, February 6, 2017.

⁵⁵ Human Rights Watch interview with an endocrinologist, February 1, 2017.

If I tell you I'm going to operate on you, but if we don't there's a 50 percent chance you'll never need the operation.... If you just give that much information to a surgeon they're going to say, "why the hell would I do it?" And most patients would also say the same thing. And so in the cases of CAIS [Complete Androgen Insensitivity Syndrome], I advocate that surgery—vaginoplasty in particular since it is often required for these women who want to have an active sexual life—should be done when this person can say they want to use their vagina for sex.⁵⁶

However, an endocrinologist on a DSD team at a regional referral hospital said that, while she observed many of her peers in DSD care speaking publicly about a decrease in medically unnecessary surgeries on intersex children, "Most patients at our center have cosmetic surgery to their external genitalia." She said: "The main two groups that don't are the kids who are being raised female who have very mild virilization, and then the more developmentally delayed kids."⁵⁷

A psychologist on a DSD team told Human Rights Watch his advice to parents is: "Probably less is more.... If you don't absolutely need to do surgery, don't do it." He said: "My voice is always in that direction and I would say the rest of my team is moving in that direction." However, he said: "There are surgeries being done all around the country."⁵⁸

A mental health provider on another DSD team said she observes similar patterns—and surgeries continue. The problem, she explained to Human Rights Watch, is that some providers believe they are providing sufficient—and sufficiently clear—information, while parents fail to comprehend what is happening. She said:

I've seen surgeons present to families in a way they couldn't possibly understand, and then not present doing nothing as a viable option...and then think that they went through a full informed consent process. And clearly, they had not. They presented it basically as: 'You can medically neglect your child, or you can do surgery...' and used words that I didn't

⁵⁶ Human Rights Watch interview with a urologist, February 15, 2017.

⁵⁷ Human Rights Watch interview with an endocrinologist, February 23, 2017.

⁵⁸ Human Rights Watch interview with a psychologist, January 30, 2017.

even understand, then gave them a form to sign and they want to do it because he has a white coat on and they're scared.⁵⁹

Other practitioners spoke of cases when they felt they needed to reject parents' demands for surgery. One endocrinologist explained that while such instances were rare, "Sometimes we have to say: 'I'm sorry. We're not going to do that here. You can go to another surgeon if you would like to do that but we don't think that it's the right thing for your child at this time.'"⁶⁰ A urologist Human Rights Watch interviewed offered an example of a case in which he convinced parents to decline genital surgery. The patient was an 8-year-old with CAH whose genitals were, the doctor said, "amazingly virilized." According to the doctor, "in talking with this kid, they very clearly did not fall into one gender role or another.... So my very strong recommendation to them actually was 'we should really think about putting in a hormone blocker in her and just [give] her some time.'" The doctor explained to Human Rights Watch:

From my perspective, [a hormone blocker] is never a wrong answer because you buy time. If you look at the transgender kids—because there really isn't any data on this in DSDs—just putting on a hormone blocker actually drops her suicidality by about 80, 90 percent. So to me this is a no brainer. You know moving ahead with a massive clitoral reduction on this kid ... who may or may not want to be a boy or may or may not want to be a girl—that's an irreversible step. And to me that is a horrible disservice to this kid.⁶¹

Some providers Human Rights Watch interviewed explained how they invested time in debunking myths that parents believed. For example, a mental health practitioner on a DSD team cited the "middle school locker room" fear as an example, saying he asks parents whether they actually showered naked in front of their peers or know that it is mandatory in their local schools. "There was a time [when that was common] perhaps but it is much less so now. And certainly children can avoid having to do that for so many

⁵⁹ Human Rights Watch interview with mental health social worker, December 4, 2016.

⁶⁰ Human Rights Watch interview with an endocrinologist, February 27, 2017.

⁶¹ Human Rights Watch interview with a urologist, February 23, 2017.

reasons that do not draw attention to themselves,” he said.⁶² Indeed this is a commonly cited fear⁶³—though not necessarily one based in reality.⁶⁴

A urologist on a DSD team said they try to steer the parents’ narrative away from “Hey, can you fix this?” She said: “I don't think that for anything elective it makes any sense to make an immediate decision. We try to explain that there is no urgency.... So the first step is just letting that sink in with the family because I don't think it occurs to most of them that not having surgery is even an option.” Her clinic presents surgery as an option by giving examples: “We say: ‘Here are some of the reasons people choose surgery. Here are some of the reasons people choose not to.’” However, she observes: “I don't think there's any way that we can be totally non-biased because we're medical people and we talk in a certain way.”⁶⁵ Another urologist echoed this sentiment, saying: “There's no such thing as a value-free consultation.”⁶⁶

Other providers expressed their conflicted feelings about the default-to-surgery paradigm by exploring hypotheticals were there to be a ban on medically unnecessary operations. For example, an endocrinologist with decades of experience treating intersex children explained:

I can't think of a case right now where [doing medically unnecessary surgery] would be applicable but I don't want to be the one that says ‘never’...I'm just never comfortable with ‘never’...I don't know. I honestly can't think of a case where I would be likely [to recommend a medically unnecessary surgery]. I mean, ‘no’ would be the right answer most of the time—probably all of the time—but I don't want to find myself in a position one day of: ‘Well this is really important to have done.’ But I can't imagine one either.⁶⁷

⁶² Human Rights Watch interview with a psychologist, January 30, 2017.

⁶³ Mireya Navarro, “When Gender Isn't a Given,” *The New York Times*, September 19, 2004, <http://www.nytimes.com/2004/09/19/fashion/when-gender-isnt-a-given.html>

⁶⁴ Anne Tamar-Mattis, “What About The Locker Room?,” *Healio Endocrine Today*, March 2009, <http://www.healio.com/endocrinology/reproduction-androgen-disorders/news/print/endocrine-today/%7B1736e672-6bcc-4334-a558-055c690794b4%7D/what-about-the-locker-room>

⁶⁵ Human Rights Watch interview with a urologist, February 6, 2017.

⁶⁶ Human Rights Watch interview with a urologist, February 15, 2017.

⁶⁷ Human Rights Watch interview with an endocrinologist, February 27, 2017.

Others explored the roots of the paradigm—insofar as it relies on stereotypes about what a “typical” male or female body should look like and how it should function during heterosexual intercourse. For example, a gynecologist who treats intersex children said:

When we’re trying to force people into cultural normative, hetero-normative situations, there’s a high chance that we’re going to make some major mistakes and harm people irreparably.⁶⁸

⁶⁸ Human Rights Watch interview with a gynecologist, March 7, 2017.

Parents Anxious About Being Misled

I think more and more families are concerned about surgery on their kids. I think that the current FDA statement regarding prolonged anesthetic in children.... Once that gets out there more I suspect that will also influence families.

—Pediatric surgeon⁶⁹

Several of the parents Human Rights Watch interviewed—including parents who had elected medically unnecessary surgeries for their intersex children and those who had not—described the anxiety they felt when communicating with doctors about their child’s intersex condition. Some felt outright bullied, intimidated, and lied to. Others said their experience left them feeling like the providers charged with advising them on their child’s healthcare were judging them based on arbitrary values, and not medical evidence.

Thomas, the father of a two-year-old with Congenital Adrenal Hyperplasia (CAH)—one of the most common conditions that can cause intersex traits—told Human Rights Watch he and his wife met with multiple specialist teams within a year of their daughter being born in 2015, and received advice based not on data but on doctors’ personal opinions of atypical genitalia. For example, one urologist told him that leaving his daughter’s genitals intact would put her at 75 percent risk for a UTI. Thomas told Human Rights Watch: “Doctors provided us with [information] that’s not backed up in the literature. It’s stuff that has just always been done in medicine.” He continued:

The doctors essentially presented us with [a series of] arguments that went from ‘she won’t remember the surgery if you get it done now’ to ‘and then the skin is more plastic when she’s younger’ to ‘the outcome literature that is spotty in terms of success because it’s based on antiquated techniques these newer techniques are going to have even better outcomes’ to ‘she will avoid any social or uncomfortable experiences based on her anatomical difference,’ and finally to ‘the risk of UTI is high’—that was every doctor’s last resort when we asked questions, to talk about the UTI risk.

⁶⁹ Human Rights Watch interview with a pediatric surgeon, April 28, 2017.

Thomas told Human Rights Watch he and his wife, Tracey, who were open to the idea of doing surgery on their daughter, sought out a specialist physician who could explain the risks, benefits, and medical necessity of the operation, but never received information that corresponded with the medical literature they had read.

As Thomas explained, the urologist asserted there was a 75 percent risk of UTI, but could not say where that number came from:

[The doctor] said: '75 percent.' So I replied: 'OK where did you get that number from ... I have not found that in what I've read.' And he said: 'Well it's just kind of in my experience.' So I asked: 'How many children have you seen who have not had the surgery and what are their rates of UTI?' And he said: 'Well I don't know.'

Thomas was upset. As a clinician, he had access to medical databases, so he researched the topic. "It's not 75 percent because if that's out there somewhere it is well-hidden. I have scoured every database that I could find." There is no reliable evidence that genital surgery will reduce rates of UTIs in children with intersex traits— in fact, surgery may increase UTI risk.⁷⁰

Thomas and Tracey echoed what Human Rights Watch heard from other parents—that the tone of the consultations suggested the doctors thought they, in rejecting surgery, were being bad parents. Tracey said: "The doctor said she would come to us begging for the surgery. Our five-month-old daughter—he could just tell that she would come to him for surgery."⁷¹ Meanwhile, Thomas said: "Nobody told us about the effects, the potential effects of the anesthesia on a child under the age of two years let alone a six-month-old, or the possibility of frequent revision surgeries—which is really the professional advice we wanted to get."

⁷⁰ Wang and Poppas, "Surgical Outcomes and Complications of Reconstructive Surgery in the Female Congenital Adrenal Hyperplasia Patient: What Every Endocrinologist Should Know," *Journal of Steroid Biochemistry and Molecular Biology*; Zeina M. Nabhan, et al., "Urinary Tract Infections in Children with Congenital Adrenal Hyperplasia," *Journal of Pediatric Endocrinology and Metabolism* vol. 19 (2006).

⁷¹ Human Rights Watch interview with Tracey A., location withheld, December 6, 2016.

Thomas and Tracey—like other parents of children with intersex traits—were left feeling isolated, but determined to make the best decision for their child’s health and future. Thomas said:

The world can be a hard place for people who are different and I am not naive to the fact that this could create some social difficulties for my daughter. However, I don't think the solution is to subject her to anesthesia and perform a surgery without her consent that's irreversible.⁷²

A mother of two children with intersex traits explained what she saw as the core struggle parents often face:

We aren’t inclined to think about our kids as humans who are going to be adults one day. We are consumed with protecting our child. If a doctor says your child is going to have a really hard time growing up with genitals that look different and I can do this surgery that will make everything fine and they won’t remember it, you’re going to say OK.⁷³

⁷² Human Rights Watch interview with Thomas A., location withheld, December 6, 2017.

⁷³ Human Rights Watch interview with Kate R., location withheld, December 4, 2017.

Lack of Informed Consent

Both international human rights and US medical standards uphold informed consent as a pillar of medical ethics. Providers are required to give sufficient and accurate information needed for patients to provide informed consent, especially when the consequences of surgery on a child's genitals or internal reproductive organs can include scarring, incontinence, loss of sexual sensation and function, psychological trauma, risk of anesthetic neurotoxicity, sterilization, the need for lifelong hormonal therapy, and irreversible surgical imposition of a sex assignment.

In some cases Human Rights Watch documented, the presentation of information as well as the content of information provided by doctors didn't give parents of intersex children a chance to provide informed consent in a meaningful way.

Providers Human Rights Watch interviewed maintained that they provide all options and share relevant scientific information with patients and their families. However, the parents of intersex patients Human Rights Watch interviewed had different experiences with medical practitioners, ranging from having doctors who were kind and supportive at first but turned dismissive when parents questioned their surgery recommendation, to doctors who provided them with incomplete or misleading information.

Judy and Carl, parents of a child with an intersex condition, said they experienced intense confusion when their child was born with atypical genitals in 2009, and doctors first assigned the child female—then four days later, male. They took their healthy baby home without a DSD diagnosis, and with a lot of lingering questions.

Two weeks later, Judy and Carl took their baby to a regional hospital to meet with an endocrinologist and a urologist. “They sent us for blood work, and a battery of other tests. They measured the phallus—there was no urethra in the little nub,” Carl said. A week later they went back and the endocrinologist told them there were no androgen issues, it probably wasn't AIS [Androgen Insensitivity Syndrome]. All other tests were inconclusive so the doctors recommended testosterone. “Let's fix the mechanics anyway,” the urologist told them. “Your son can have any size penis he wants!”

Judy and Carl agreed to the surgery when their child was 11 months old, in April 2010. The procedure required a follow-up surgery eleven months later that resulted in two post-operative infections. Two days after the family was released from post-operative infection

care, a letter arrived in the mail telling them their son, Jack, had tested positive for Partial Androgen Insensitivity Syndrome (PAIS). This meant that, according to medical data, his future gender identity was uncertain and his body would not respond like most boys to testosterone as he grew up. Judy told Human Rights Watch: “After we’ve now gone through two surgeries and we had no idea of what to think of for the next 20 years ... what’s damaged or what’s not ... the whole spectrum of horror.”

The experience left the parents devastated, and feeling betrayed. Their child, now 8, ultimately developed a female gender identity. She lives as a girl at home and school, and family and friends call her “Jackey.” The social transition from Jack to Jackey was smooth, but the effects of surgery will not be so easily undone.

“We are smart enough to rationalize things and think through the outcomes,” said Judy, wishing that they had had better information and support during the decision-making process. “It’s frustrating, we’re angry,” said Carl. “We beat ourselves up about this” Judy explained: “I want to give [the doctors] the benefit of the doubt. I can’t definitively say that they didn’t think the surgery was the right thing to do. But they certainly did not have the information they needed—even a diagnosis—and nobody interjected to slow everything down.” Carl said:

The doctors told us it was important to have the surgery right away because it would be traumatic for our child to grow up looking different. What’s more traumatic? This sort of operation or growing up a little different?⁷⁴

A pediatric surgeon Human Rights Watch interviewed expressed similar views about differences in children. She said she tries to explain to parents that “many children have differences,” explaining that:

We deal with kids with all kinds of vascular anomalies and port wine stains. And we encourage those children to be out there, we encourage those children to be in school—and they are and they do great. We’ve got kids

⁷⁴ Human Rights Watch interview with Carl B., location withheld, January 26, 2017.

with Ellis Von Creveld⁷⁵ and Treacher Collins⁷⁶ who are totally well integrated into the school and they have significant facial anomalies. And I think that it speaks to the strength of the family and the strength of the child and the support of the care team that you can have a difference and you can go out there and we don't need to necessarily create normalization to make you safe and well adjusted. ⁷⁷

⁷⁵ Ellis van Creveld (EvC) syndrome, also known as chondroectodermal dysplasia, is characterized by abnormalities in the skeleton. These abnormalities include short arms and legs, extra fingers and/or toes, and a narrow chest.

⁷⁶ Treacher Collins syndrome is a genetic, craniofacial condition that is characterized by a range of distinctive facial anomalies.

⁷⁷ Human Rights Watch interview with a pediatric surgeon, April 28, 2017.

Intersex Children Can Thrive Without Surgery

In July 2017, the AIS-DSD Support group—the largest intersex adult, children, and family support group in the US—joined Human Rights Watch in writing to the AMA to share our report on intersex issues. In the letter, supporting a proposed AMA resolution on optimal management of DSD through individualized, multidisciplinary care, AIS-DSD explained:

If the AMA adopts the proposed [Board of Trustees] resolution, we hope that the AIS-DSD Support Group will be able to shift the focus of our support efforts over time away from helping adults, youth and their families recover from medically-induced traumas, and toward support of the physical and psychological health of our members, from birth to old age.⁷⁸

Over time, support groups have been able to help parents resist pressures to elect high-risk and medically unnecessary irreversible procedures on their children. While much of the narrative of the intersex human rights movement has focused on the stories of intersex people who underwent non-consensual surgeries and suffered physical and psychological fall-out from the procedures, some intersex youth who did not undergo surgery have begun speaking out as well. Recent video segments produced by *Teen Vogue*⁷⁹ and *Buzzfeed*⁸⁰ showcase intersex youth who have not undergone surgeries, despite pressure from doctors to do so.

A 2017 *Harper's* investigative report from the Dominican Republic, where most intersex children are left intact, showed that social awareness, and parent and teacher response help mitigate bullying—as with any other kid.⁸¹ Intersex activist Hida Vilorio, who did not have surgery, told *Rolling Stone* in 2017 about her decades of telling her story publicly:

My goal was that a parent who might have recently had an intersex child or have one in the future would see my interview and think, ‘Oh, being

⁷⁸ See appendix IV

⁷⁹ Teen Vogue, “What Was Done to These Intersex People Was Not Okay,” June 18, 2017, <https://www.youtube.com/watch?v=mT4dDO-ZwcQ>

⁸⁰ BuzzFeed, “What It’s Like to Be Intersex,” March 28, 2015, <https://www.youtube.com/watch?v=cAUDKEI4QKI>

⁸¹ Sarah Topol, “Sons and Daughters—The village where girls turn into boys,” *Harper's*, August 2017, <https://harpers.org/archive/2017/08/sons-and-daughters/>

intersex is fine and this person has been able to grow up happy and successful and feel good about themselves. There's no reason I have to cut up my child's body in this non-consensual, irreversible way. I'll just let them grow up and decide later on if they want to change anything about their body, the way most people get to decide.’⁸²

Emerging data, while limited, support these observations. A 2017 paper published in the *Journal of Pediatric Urology* documented, in follow-up with seven girls with CAH up to age eight who did not have surgery, that “girls and their parents have not expressed significant concerns regarding genital ambiguity.” The authors conclude: “With these encouraging data at hand, we propose to formally address levels of anxiety, adaptation and quality of life during childhood, with an ultimate goal to assess long-term satisfaction and effects on sexuality through deferring genital surgery.”⁸³

⁸² *Rolling Stone*, “Intersex Activist and Writer Hida Viloria on Being 'Born Both',” March 20, 2017, <http://www.rollingstone.com/culture/intersex-activist-hida-viloria-on-being-born-both-w472894>

⁸³ Pierre Bougnères, “Deferring Surgical Treatment of Ambiguous Genitalia into Adolescence in Girls with 21-Hydroxylase Deficiency: A Feasibility Study,” *International Journal of Pediatric Endocrinology* 2017(3) (2017), DOI 10.1186/s13633-016-0040-8.

The Positive Role of Peer Support Groups

International DSD consensus statements and the World Health Organization have emphasized the positive role and importance of support groups. Many providers Human Rights Watch interviewed cited various ways they referred patients to support groups including directing them to websites of established groups such as CARES Foundation, AIS-DSD Support Group, or the Accord Alliance, or putting parents in touch with other parents within the hospital clinic's network.

However, many parents of intersex children reported a range of encounters with providers in regard to support groups. Some parents said that doctors provided information about such groups as a part of the regular care of their child, others said that doctors did not proactively offer information, and still others reported that they were told no such resources existed.

Regardless of how parents found support groups, across the board they expressed that the groups were life-affirming and helpful for the entire family. These groups not only helped intersex children and their parents feel like they were not alone, but they were a source of practical support, providing tools on how parents can best advocate for their children.

For intersex adults, too, accessing support groups was invaluable in gaining confidence, combatting shame and stigma, and accessing information.

Another study, published by doctors at Seattle Children's Hospital in 2017, showed that even in a case where parental discomfort with bodily difference was motivating them to elect a medically unnecessary gonadectomy on their child, and doctors wanted to carry out the parents' wishes, hospital and state ethics and sterilization policies required that the procedure be deemed medically necessary, or else let the child decide later. The paper explained:

While the DSD team supported the parents' decision for gonadectomy, hospital policy and interpretation of Washington state law prohibits parents from providing informed consent for any procedure that removes the reproductive organs of a minor (Disability Rights Washington, 2012; Seattle Children's Hospital Bioethics Policy, 2013). Exceptions are allowed if they pose a health risk, such as the oncogenic risk posed by dysplastic gonads and/or if infertility is considered inevitable with standard treatment (Seattle Children's Hospital Bioethics Policy, 2013). A court order

authorization must be obtained for any other exception. Given the knowledge available on 5 α -R2D and the patient at the time, the medical team felt this policy precluded them from offering gonadectomy to the patient without a court order.⁸⁴

What is more, doctors who work with intersex patients are increasingly understanding the advice they give parents in the context of physicians' role in caring for children with a range of differences. A pediatric surgeon told Human Rights Watch:

I live in a community where I know we have two Treacher Collin's kids in our high school. And they are well integrated and I see them in the school I see them out in the streets of our village with friends. And if those kids can do that with their facial anomalies and their surgeries and their reconstructions so that they can safely breathe, they can eat, they can swallow, I am sure that with the appropriate support and the appropriate attitude we can keep our DSD kids safe and well-integrated and well-adjusted in their school and their growing up environments without cosmetically oriented surgeries.⁸⁵

⁸⁴ Heather Byers, et al., "Unexpected ethical dilemmas in sex assignment in 46,XY DSD due to 5-alpha reductase type 2 deficiency," *American Journal of Medical Genetics*, June 2017, 175(2):260-267, <https://www.ncbi.nlm.nih.gov/pubmed/28544750#> (accessed July 3, 2017).

⁸⁵ Human Rights Watch interview with a pediatric surgeon, April 28, 2017.

Recommendations

In our July 25, 2017 report, Human Rights Watch and interACT made recommendations to a range of government, law enforcement, and medical bodies. The recommendations below are a selection of those specifically targeted at medical bodies:

To the American Medical Association

- As a matter of urgency, pass the proposed resolution as recommended in the AMA Board of Trustees report 7-I-16, that “optimal management of DSD through individualized, multidisciplinary care...: (1) seeks to foster the well-being of the child and the adult he or she will become; (2) respects the rights of the patient to participate in decisions and, except when life-threatening circumstances require emergency intervention, defers medical or surgical intervention until the child is able to participate in decision making; and (3) provides psychosocial support to promote patient and family well-being.”⁸⁶

To the American Psychological Association

- Issue a resolution on the treatment of intersex children recommending:
 - A moratorium on surgeries performed on children with atypical sex characteristics too young to participate in the decision, when those procedures both carry a meaningful risk of harm and can be safely deferred;
 - inclusion of psychologists/mental health care in treatment teams; and
 - discussion of risks, benefits, and alternatives to any proposed treatment with psychologists/mental health providers prior to any irreversible decisions.

To the American Academy of Pediatrics

- Retract the support of the AAP for the 2006 Consensus Statement as an official position statement of the AAP, and replace it with a statement that is consistent

⁸⁶ American Medical Association, “Report of the Board of Trustees: B of T Report 7-I-16: Supporting Autonomy for Patients with Differences of Sex Development (DSD) (Resolution 3-A-16),” <https://assets.ama-assn.org/sub/meeting/documents/i16-bot-07.pdf>.

with international human rights standards and with the AAP statements on Assent, Informed Permission and Consent, and on FGM. The new statement should also:

- advocate to end to surgical procedures on children with atypical sex characteristics too young to participate in the decision, when those procedures both carry a meaningful risk of harm and can be safely deferred;
- advise that parents be given complete information about their intersex child's condition and the risks, benefits, and alternatives of any recommended procedures;
- advise that children and youth with atypical sex characteristics be given complete information about their conditions in an age-appropriate way;
- recommend that doctors routinely give parents of children with atypical sex characteristics information about available peer support groups; and
- recommend that parents routinely have access to mental health support and information from mental health experts about their child's condition before making irreversible decisions about their child's health.⁸⁷

To the World Health Organization:

- In line with WHO's stated opposition to early genital or sterilizing surgeries on intersex youth in the 2013 report "Eliminating Forced, Coercive and Otherwise Involuntary Sterilization," issue guidance on how medical professional bodies and governments should combat such practices.

To the Society for Pediatric Urology, the Pediatric Endocrine Society, and the North American Society for Pediatric and Adolescent Gynecology:

- Issue guidance in line with the proposed AMA resolution as recommended in the AMA Board of Trustees report 7-I-16 "that medically unnecessary surgeries in individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making."

⁸⁷ Such a statement would bring AAP policy regarding children with atypical sex characteristics in line with existing AAP policy on Assent, Informed Permission and Consent, and on FGM.

To the World Professional Association for Transgender Health:

- Remove the intersex exception from WPATH's Standards of Care and assert that similar standards for the sequence of interventions be applied to intersex children facing partially reversible or irreversible procedures that are not necessary for physical health.

Acknowledgments

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The report was reviewed by Kimberly Zieselman, executive director of interACT, Sylvan Fraser, staff attorney at interACT, and Alesdair Ittelson, legal and policy director at interACT.

Graeme Reid, director of the lesbian, gay, bisexual, and transgender rights program at Human Rights Watch edited the report. Grace Meng, deputy US program director, Megan McLemore, senior health and human rights researcher, and Michael Garcia Bochenek, senior children's rights counsel reviewed the report. Chris Albin-Lackey, senior legal adviser, and Joseph Saunders, deputy program director reviewed the report. Production assistance was provided by MJ Movahedi, LGBT rights program associate; Madeline Cottingham, photo and publications coordinator; Fitzroy Hepkins, administrative manager; and Jose Martinez, senior coordinator.

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Appendix I

October 13, 2016

Dear Dr. XXXX:

I am a researcher at Human Rights Watch, an international non-governmental research and advocacy organization.

Human Rights Watch conducts research on a range of issues in more than 90 countries around the world, including the United States, where we are headquartered. Our research is designed to be objective, and take into account all perspectives so that we can conduct accurate legal and policy analysis.

I am currently undertaking a research project focusing on the experiences of intersex people in the United States. Specifically, we are interested in hearing from practitioners about medical care options available for intersex infants (or infants with DSD) and the advice and information provided to their parents. To better understand the experience of intersex children and their parents, we seek to interview healthcare providers such as yourself about the care and information you and your colleagues provide. We are also interested in interviewing any patients of yours, or their parents, to learn about their experiences living with intersex conditions and seeking care.

We are able to meet with you in person or on the phone at a mutually convenient time. The results of our research projects are public reports that are available in print and online. We are willing to anonymize the information you share with us and if you prefer, we can assure any information you share with Human Rights Watch is featured without any identifying characteristics, including name, location, exact date of the



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interview, and other possibly identifying aspects. We have undertaken the Ethical Review Board process operated by Physicians for Human Rights to ensure this research is carried out with the highest standards of professional care.

We recognize that this can be a polarizing and difficult topic, and our aim is to ensure that our research is objective and that it fully captures the whole range of different perspectives at play.

I am based in New York City, and available to answer any questions you might have in advance of arranging an interview. I can be reached at kyle.knight@hrw.org, or 917-794-6690.

I look forward to hearing from you regarding this meeting.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kyle Knight', with a stylized, overlapping loop structure.

Kyle Knight
Researcher, Human Rights Watch

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Appendix II

January 18, 2017

Dear Dr. XXXX:

We wrote on October 13, 2016 requesting an interview regarding your clinic's practices with patients with disorders of sex development for an ongoing research project, and this letter is a follow up request to provide information in writing.

As mentioned in our previous correspondence, Human Rights Watch is attempting to gain a wide range of perspectives to incorporate into our report—a methodology we apply in all of our research. You can see examples of our research on a range of issues on our website at www.hrw.org.

Two examples of health-specific projects we have recently conducted are *"No Time to Waste" – Evidence-Based Treatment for Drug Dependence at the United States Veterans Administration Department of Veterans Affairs*,⁸⁸ and *Care When There Is No Cure – Ensuring the Right to Palliative Care in Mexico*.⁸⁹

For this project, we are attempting to gather a wide range of perspectives on the following topics, and we would appreciate your responses to the questions below by February 10, 2017:

- What is the process for communicating with parents regarding their child's intersex (DSD) diagnosis and treatment options?
- In addition to speaking with doctors and nurses, what resources exist for parents to learn about their child's condition?

⁸⁸ "No Time to Waste" can be found at <https://www.hrw.org/report/2014/06/30/no-time-waste/evidence-based-treatment-drug-dependence-united-states-veterans>

⁸⁹ Care When There Is no Cure can be found at http://features.hrw.org/features/HRW_2014_report/Mexico_Care_When_There_Is_No_Cure/index.html



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- What cases are considered to be candidates for surgery (genital or gonadal)?
- If a child is considered a candidate for surgery, how is the option of surgery presented to parents?
- If parents opt not to have surgery, what advice and resources are provided to them?
- For patients who have undergone surgeries in your clinic, what follow-up is advised and conducted?

If you would prefer to speak on the phone instead, please feel free to contact me to arrange a time.

As mentioned in our prior correspondence, Human Rights Watch is interested in interviewing people with DSDs who have undergone various treatments, in particular related surgeries. This is so that we can establish how the procedures have impacted their lives—including their ability to live openly according to their gender identity, form relationships, establish a positive self-concept, access ongoing healthcare, and engage in employment. We would be happy to have you share our contact information with any of your current and/or former patients who might be interested in speaking with us. We are particularly interested in interviewing individuals with DSDs who are pleased with the surgical interventions they received as children.

As reflected in the reports linked above, all of our interviews, with patients or providers, will be anonymized and are conducted with full informed consent regarding our objectives and methodology. We are keen for our report to contain a wide range of perspectives on these issues, and we understand the topics can be polarizing and challenging. Please consider participating so that your expertise and experience can be reflected in our research.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kyle Knight', with a stylized, cursive-like script.

Kyle Knight
Researcher, Human Rights Watch

Appendix III

November 24, 2015

**To: NIH Translational Research Network and NIH Research Coordinating Committee
For Sexual and Gender Minorities**
From: AAN Members
Re: Statement of resignation of some AAN Members from TRN

The original invitation to join the Advocacy Advisory Network (AAN) of the NIH Translational Research Network (TRN) evoked an idealistic vision of patients and clinicians setting aside differences and working together to make life happier and healthier for people living with reproductive difference. Rejoicing at the opportunity to have a voice in major decisions about research and care that affect our community in powerful ways, representatives of multiple peer support and advocacy groups eagerly joined. AAN members include advocates with diverse lived experience, who are affected adults, parents, and children, who are affected by a variety of differences, and who range in life stage from youth to maturity. We bring skills from careers in business, academia, law, social work, conflict resolution, project management, counseling, psychology, genetics, non-profit executive directorship, and medicine. We have decades of combined experience in peer support and leadership. Additionally, for the upcoming Global DSD Update sponsored by Pediatric Endocrine Society, Arlene Baratz is co-chair of the committee on patient perspectives and peer support. Despite our representation of our community and many valuable contributions of expertise and experience since we joined AAN four years ago, we are extremely disappointed that TRN has not lived up to its initial promise.

Alice Dreger and Tiger Devore recently announced their resignations from AAN on Alice's blog. We agree with some of their ideas, and would like to clarify our own perspective. AIS-DSD Support Group, Advocates for Informed Choice, and our allies listed below are also withdrawing from AAN because of ongoing miscommunication and lack of meaningful inclusion. At this point, having our names associated with TRN is doing more harm than good because chronic issues with TRN prevent meaningful advocacy input. From its inception, despite our requests, TRN failed to include advocates in the design and goals of the project. Having been denied a presence at the initial meeting of investigators, we hoped that subsequent close involvement in projects could influence the direction of research, but most were already IRB-approved by the time we saw them. Instead of an opportunity to contribute, we have experienced a pattern of misrepresentation in which our involvement and concurrence have been falsely implied. Missed deadlines and absence of key project deliverables also frustrate us.

Let us be clear that our resignation has nothing to do with the TRN clinicians and researchers who devote their lives to caring for and about us. We deeply appreciate your presence at our support group meetings, your availability to our members, and your ability to listen and change. Outside TRN, we are delighted to be involved in ongoing projects whose design and goals reflect successful cooperative relationships. We have found we can be extremely effective in supporting the development of research that meets the needs of our communities when we are involved from the beginning in the design of research goals, when we are able to give input into sensitive language, and when we are engaged to ensure that the specific concerns of this community regarding human research ethics and informed choice are addressed. Examples of successful research we have engaged in include projects on parent experiences with making decisions about genital difference; how young women living with DSD share health information

11/24/15, re: AAN membership

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with peers; and parent experiences with genetic testing. Currently, we are working with TRN clinicians on outside projects investigating language, how medical care is experienced, ways to deliver psychosocial care, and evidence-based best practices in CAIS. We look forward to future opportunities to work with anyone from within or outside TRN who is interested in designing research that is inclusive of community concerns.

Although clinicians may have interacted with Accord Alliance as the designated community representative, we found that indirect transmission was effectively censoring our written and verbal communications. This is disturbing because Accord Alliance was founded in 2006 by Bo Laurent (Cheryl Chase), Katrina Karkazis, Arlene Baratz, and David Sandberg to improve medical care by replacing ISNA's confrontational tactics with a fresh, collaborative approach involving multiple stakeholders. At its closure, ISNA's funds and assets were transferred to Accord Alliance, including the *Handbook for Parents* and *Guidelines for Clinicians*. Accord Alliance hosted a research and quality improvement symposium in 2009, but hasn't sponsored any non-medical events since then, according to its blog. Laurent, Karkazis, and Baratz are no longer involved. Supported in its early days by community donations, Accord Alliance's current major source of funding is the TRN grant, which in turn designates the function of DSD community representative to Accord Alliance. This suggests a major conflict of interest. Reinforcing this impression is TRN's repeated failure to share AAN opinions and concerns about various projects with TRN clinicians. For example, serious and widespread AAN concerns that a proposed photography project posed potential harm to pediatric research subjects were not conveyed accurately to clinicians. When the time came to submit that proposal, clinicians were surprised to learn our opinion. Having further misled clinicians to believe that only a minority of AAN members requested further input on the proposal, TRN circumvented its requirement for AAN support with a letter from Accord Alliance implying our approval. It was an embarrassment to all of us that the proposal was withdrawn after AAN protested the deceptive letter.

Similarly, AAN members were extensively involved for four years in writing and editing numerous drafts of educational material for a TRN family decision support tool. However, ever since we insisted recently that families be made aware of major international human rights policies involving DSD treatment, our contributions are mysteriously absent. Despite our repeated requests, a version of the decision support tool omitting human rights education is already being piloted with families. Ethics and common decency suggest that shared decision-making should include informing families that many international human rights organizations have new statements strongly affirming the right of children with diverse sex characteristics to make their own choices about irreversible interventions. The [UN High Commissioner for Human Rights](#) and the [UN Special Rapporteur on Health](#), working closely with Advocates for Informed Choice (AIC), have both endorsed these as basic human rights. DSD/intersex is increasingly prominent on an international landscape in the midst of tectonic shifts. AIC will continue to advocate for an informed consent process requiring family counseling to include discussion of both social and medical controversies. Otherwise, how will children feel later when they discover that their parents made important decisions about irreversible interventions using decision support tools that consciously excluded vital information on children's human rights? Parents have a right to know just how controversial these procedures are before they make irreversible decisions.

Finally, the original TRN grant proposal included individual letters of support from AAN member organizations. In May, we were asked to draft a new letter jointly supporting a proposal to fund

TRN for the next funding cycle. After requesting changes in the grant to provide AAN more direct involvement as a condition of support, we never saw such a letter. The grant was later submitted, leaving us to wonder if the controversy was resolved by submitting a letter from Accord Alliance without our knowledge. If so, another five years of advocate dissatisfaction and AAN misrepresentation of our constituents concerns are practically guaranteed.

AIS-DSD Support Group's mission is to foster successful stakeholder collaborations that promote community well being through peer support, informed decision-making, and advances in evidence-based care. You see our passionate commitment in the vibrant community of affected people, clinicians, and allies that we nurture. You see it at the annual continuing education meeting we sponsor in partnership with DSD teams around the country. You see it when you attend our support group meetings, hear how people experience treatment, and learn about research that matters to patients. Likewise, AIC's mission is to advocate for the legal and human rights of children born with intersex traits. Neither organization, however, can effectively support or advocate for our constituents through the AAN, and so our consciences dictate that our members must resign.

All of us see how hard you work and how much you care. We know you want to see intersex people thrive as much as we do. The world is already changing because of our mutual dedication. Together, we have the power to transform it and we look forward to further collaborations outside the TRN.

Sincerely,

Arlene B. Baratz, MD
Coordinator of Clinical and Research Affairs AIS-DSD SG
Moderator, AIS-DSD Parents Group
AIC Board of Directors and Medical Adviser

Tiger Devore, PhD
Founding member, past president and vice president, Hypospadias Epispadias Association

Amber Jones
Operations Coordinator, AIS-DSD Support Group
Moderator, AIS-DSD Parents Group
Past member, AIS-DSD SG Board of Directors

Jim Lake
Executive Director, Hypospadias Epispadias Association

Lissa Moran, MPH

Meg Robertson
AIS-DSD SG Board of Directors
Moderator, AIS-DSD Parents Group

11/24/15, re: AAN membership

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Karen Walsh
AIC board of directors

Kimberly Zieselman, JD
Executive Director, Advocates for Informed Choice
AIS-DSD SG Board of Directors

11/24/15, re: AAN membership

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Appendix IV

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August 15, 2017

David O. Barbe, MD, MHA
President, Board of Trustees

Dennis S. Agliano, MD, FACS
Chair, Council on Ethical and Judicial Affairs

American Medical Association (AMA)
330 N. Wabash Ave. Suite 39300
Chicago, IL 60611-5885

Dear Dr. Barbe and Dr. Agliano:

We write to share with you the first ever in-depth report on the treatment of intersex youth in the United States. AIS-DSD Support Group wrote to you previously on May 19, 2017, and Human Rights Watch corresponded with the AMA's Physician Engagement Department on July 12, 2017.

As you may know, Human Rights Watch is an international non-governmental research and advocacy organization that works in more than 90 countries and is headquartered in the United States. AIS-DSD Support Group is the largest organization in the US exclusively dedicated to promoting support, education, and outreach to foster healthy outcomes for adults, youth, children, and families affected by intersex conditions, also known as Differences of Sex Development (DSD). AIS-DSD Support Group runs an annual conference for the intersex community and creates the curriculum for and co-conducts CME classes for the clinicians (physicians, psychosocial counselors, geneticists, and DSD program coordinators) who attend the conference. AIS-DSD Support Group helped Human Rights Watch connect with affected individuals, families, and doctors to conduct interviews that are included in the report.

This report, the result of 10 months of intensive research by Human Rights Watch, recommends that the American Medical Association, as a matter of urgency, pass the proposed resolution as recommended in the AMA Board of Trustees report 7-I-16, that,

Optimal management of DSD through individualized, multidisciplinary care...: (1) seeks to foster the well-being of the child and 20 the adult he or she will become; (2) respects the rights of the patient to participate in decisions 21 and, except when life-threatening circumstances require emergency intervention, defers 22 medical or surgical intervention until the

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child is able to participate in decision making; and 23 (3) provides psychosocial support to promote patient and family well-being.

Major health and human rights organizations, including the United Nations, the World Health Organization, and Amnesty International, have condemned medically unnecessary surgeries performed without informed consent. In July 2017, three former US Surgeons General, including one who was a pediatric urologist, wrote to oppose this practice because "there is insufficient evidence that growing up with atypical genitalia leads to psychosocial distress," and "the surgery itself can cause severe and irreversible physical harm and emotional distress." Every major intersex organization opposes unnecessary surgeries on intersex infants, as does every major LGBT legal organization in the United States. AIS-DSD Support Group endorsed the recommendations of the Human Rights Watch report on July 25, 2017, when it was launched in Chicago.

Human Rights Watch, AIS-DSD, and the AMA share the goals of protecting the human rights of and promoting healthy outcomes for intersex-affected individuals and their families. The nonconsensual medically unnecessary surgeries that are performed today jeopardize the lives, health, and happiness of the intersex community. If the AMA adopts the proposed resolution, we hope that the AIS-DSD Support Group will be able to shift the focus of our support efforts over time away from helping adults, youth and their families recover from medically-induced traumas, and toward support of the physical and psychological health of our members, from birth to old age. Our support will continue to respect individual's rights to physical autonomy, including the right of older children and adults to consent to surgeries; we will also continue to provide support for parents and others who have made decisions for surgeries in the past.

For the well-being of intersex children and their families, we strongly urge the AMA to issue clear, unambiguous guidance recommending a delay of all medically-unnecessary interventions. We would be happy to meet with you—in person or on the telephone—to discuss our recommendations further.

Thank you for your time and consideration.

Kind regards,

A handwritten signature in black ink, appearing to read "Kyle Knight".

Kyle Knight
Researcher, Human Rights Watch
kyle.knight@hrw.org
917 794 6690

A handwritten signature in black ink, appearing to read "Kimberly Saviano".

Kimberly Saviano
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A CHANGING PARADIGM

US Medical Provider Discomfort with Intersex Care Practices

Since the 1960s, doctors in the United States have routinely performed surgeries on intersex infants and children – or those born with chromosomes, gonads, or genitalia that do not correspond to traditional notions of “male” or “female” – to make their bodies conform to conventional gender presentation. But the surgeries are medically unnecessary, irreversible, often traumatizing, and carry a risk of lifelong harm. They can also be safely deferred until the person concerned is old enough to decide for themselves whether they want the procedures.

Despite increasing controversy within the medical community and condemnation from human rights organizations, however, some specialist doctors continue to recommend and carry out the operations on children too young to consent.

In *A Changing Paradigm*, Human Rights Watch and interACT Advocates for Intersex Youth document the increasing discomfort healthcare providers feel with the default-to-surgery paradigm, and the growing momentum to support care standards like those for all other patients and to respect rights to informed consent and bodily autonomy.



Dr. Katharine Dalke is a psychiatrist, an intersex woman, and a mother. She advocates for an end to medically unnecessary surgeries performed on intersex children too young to consent.

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Re-Thinking Genital Surgeries on Intersex Infants

M. Joycelyn Elders, M.D., M.S.
15th Surgeon General of the United States

David Satcher, M.D., Ph.D., FAAFP, FACPM, FACP
16th Surgeon General of the United States

Richard Carmona, M.D., M.P.H., FACS
17th Surgeon General of the United States

June, 2017

On October 26, 2016, the 20th anniversary of Intersex Awareness Day, the U.S. State Department issued a statement recognizing that “intersex persons routinely face forced medical surgeries that are conducted at a young age without free or informed consent. These interventions jeopardize their physical integrity and ability to live free.”¹

The U.S. government is one of many that have recently raised questions about infant genitoplasty, cosmetic genital surgery meant to make an infant’s genitals “match” the binary sex category they are assigned by adults entrusted with their care. Genitoplasty is often performed on infants with intersex traits, a condition known as DSD, or Disorders/Differences of Sex Development. Although well-intentioned—many parents and physicians believe it is more trying for individuals to live with atypical genitalia than to have it “corrected” early on—there is growing recognition that this belief is based on untested assumptions rather than medical research, and that cosmetic genital surgery performed on infants usually causes more harm than good.

Fortunately, a consensus is emerging that concludes that children born with atypical genitalia should not have genitoplasty performed on them absent a need to ensure physical functioning. Government agencies in Germany, Switzerland, Australia, Chile, Argentina, and Malta, as well as human rights groups, including the World Health Organization, have examined this issue and found that these irreversible medical procedures, which are performed before individuals can articulate whether they wish to undergo such surgery, are not necessary to ensure healthy physical functioning, and that such surgery is not justified when performed on infants. These bodies have called for a moratorium on cosmetic infant genitoplasty so as to allow individuals with a DSD to have substantive input into decisions affecting their own identity and appearance.

Performing cosmetic infant genitoplasty was not always the default practice. Before the middle of the twentieth century, most children born with genitalia that did not fit the male-female binary norm were not subjected to surgery. Beginning in the 1950s, however, an era when pressure to conform to social norms was often unyielding, the standard treatment protocol shifted. Infants born with atypical genitalia were subjected to surgical procedures such as clitoral reduction, vaginoplasty, gonadectomy, and hypospadias repair, primarily to “normalize” gendered appearance, not to improve function.

Since this period, as a 2016 consensus statement notes, good-faith disagreement has existed among physicians about whether and when cosmetic infant genitoplasty should be performed.² Some physicians recommend surgery because they believe it will decrease the likelihood that children will suffer emotional trauma from having atypical gender characteristics. While we do not doubt that doctors who support and perform these surgeries have the best interests of patients and their parents at heart, our review of the available evidence has persuaded us that cosmetic infant genitoplasty is not justified absent a need to ensure physical functioning, and we hope that professionals and parents who face this difficult decision will heed the growing consensus that the practice should stop.

Our view is based on three simple and compelling rationales. First, there is insufficient evidence that growing up with atypical genitalia leads to psychosocial distress. After reviewing several dozen studies that purported to examine the impact of having a DSD, we have concluded there is a dearth of persuasive evidence showing that children or adults are psychologically harmed from having atypical genitalia, or that they are better off if they undergo cosmetic genitoplasty as infants. For the most part, studies that did draw a connection between atypical genitalia and emotional distress simply assumed, rather than showed, a causal link between the two.³

Second, while there is little evidence that cosmetic infant genitoplasty is necessary to reduce psychological damage, evidence does show that the surgery itself can cause severe and irreversible physical harm and emotional distress. Although doctors strive to predict the likely gender identity of these infants, a significant percentage will develop a gender identity different from the one assigned at birth. Irreversible genital surgery, including removal of healthy genital tissue, can be traumatic if the gender assignment turns out to conflict with the individual's own gender identity.⁴

Even if the gender prediction is correct, a number of complications associated with these surgeries can arise, including loss of sexual sensation, pain during intercourse, incontinence, scarring, and the need for repeat surgeries. A gonadectomy can create a need for hormone replacement therapy, and may also preclude potential fertility available through developments in assisted reproductive technology.⁵ In short, surgeries whose purpose is to ensure physical and psychological health too often lead to the opposite result.

Finally, these surgeries violate an individual's right to personal autonomy over their own future. While surgeries such as the creation of an absent urethral opening can be justified because they ensure physical functioning, neither clitoral reduction surgery nor the creation of a vagina is ever necessary in infants to ensure physical functioning, and hypospadias repair is rarely necessary. Clitoral reductions and the removal of healthy gonads clearly infringe on the child's right to physical integrity, preservation of sexual and gender identity, and procreative freedom. In some cases, a gonadectomy may be appropriate to address a risk of cancer, but this surgery can generally wait until puberty, when the affected individuals can have a voice in the decision about whether to undergo such a procedure.⁶

Medical experts agree that more research is needed to determine the optimal treatment for children born with a DSD. In the meantime, babies are being born who rely on adults to make decisions in their best interest, and this should mean one thing: When an individual is born with atypical genitalia that pose no physical risk, treatment should focus not on surgical intervention but on psychosocial and educational support for the family and child. Cosmetic genitoplasty should be deferred until children are old enough to voice their own view about whether to undergo the surgery. Those whose oath or conscience says "do no harm" should heed the simple fact that, to date, research does not support the practice of cosmetic infant genitoplasty.

¹ U.S. Department of State, “In Recognition of Intersex Awareness Day” (statement by John Kirby, Assistant Secretary and Department Spokesperson, 2016).

² Lee PA, Nordenström A, Houk CP et al. Global disorders of sex development update since 2006: perceptions, approach and care (consensus statement). *Horm Res Paediatr*. 2016;85:158–180.

³ Ibid., 167, 176.

⁴ Cohen-Kettenis PT. Gender change in 46,XY persons with 5alpha-reductase-2 deficiency and 17beta-hydroxysteroid dehydrogenase-3 deficiency. *Arch Sexual Behav*. 2005;34(4):399-410.

⁵ Hughes IA, Houk C, Ahmed SF, Lee PA. Consensus statement on management of intersex disorders. *Arch Dis Child*. 2006;91:554-562.

⁶ Deans R, Creighton SM, Liao LM, Conway GS. Timing of gonadectomy in adult women with complete androgen insensitivity syndrome (CAIS): patient preferences and clinical evidence. *Clin Endocrinol (Oxf)*. 2012;76(6): 894-898.



Through evidence,
change is possible.

Physicians for
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February 1, 2018

Dennis S. Agliano, MD, FACS
Chair, Council on Ethical and Judicial Affairs
American Medical Association
Dennis.Agliano@ama-assn.org

Dear Dr. Agliano:

I understand that the American Medical Association (AMA) Council on Ethical and Judicial Affairs (CEJA), which you chair, is currently considering a policy regarding supporting autonomy for individuals affected by differences of sex development (DSD), or intersex traits. I am aware that the AMA Board of Trustees in 2016 recommended a course of action, which prompted review by the CEJA. I write to express the support of Physicians for Human Rights for the AMA CEJA to adopt a policy that respects and upholds the human rights of intersex people by applying the central medical ethics standards of informed consent and medical necessity to their treatment.

As a physician, I understand that each clinical case is unique and nuanced, and that certain conditions cause considerable anxiety and confusion for patients, caregivers, and doctors alike. It is for this reason that it is crucial that the AMA develop clear guidelines for practitioners that medically unnecessary surgeries on intersex children such as vaginoplasties, clitoral surgeries, and gonadectomies absent malignancy not be offered as part of the standard care regimen. From a medical ethics perspective, carrying out an irreversible and medically unnecessary surgery before a child is old enough to consent violates internationally recognized informed consent requirements, and violates the obligation to do no harm. I urge the AMA to issue detailed policy to their members and constituencies on emerging best practices for the optimal management of the physical and mental health of intersex children and their families. Such guidance should include clear guidance to defer medically unnecessary surgeries until an individual can provide informed consent, and to provide psychosocial support for patients and families. Intersex-led peer support and advocacy groups have long highlighted the lack of meaningful evidence of physical or mental health benefits to intersex children deriving from early surgery, except in those limited cases where such surgeries are medically necessary. Medical experts are increasingly acknowledging this, and emerging data and standards of care favor deferring medically unnecessary surgeries.

In July 2017, three former U.S. Surgeons-General wrote that they believed “evidence [shows] that the surgery itself can cause severe and irreversible physical harm and emotional distress.”¹ Earlier in 2017, the Committee on Bioethics of the Council of Europe noted that “repeated systematic reviews of evidence have found no quality data confirming [the] safety and benefits for each affected child [of early surgical interventions]” and that, rather, there is evidence of harmful results of such interventions, including genital dysfunction, scarring, loss of sexual feeling, loss of fertility, chronic pain, and enforcing the wrong gender assignment – with irreversible excision of genital and gonadal tissues.² We also note that this position on establishing thresholds of medical necessity and informed consent for surgeries on children with intersex traits is supported by the World Health Organization,³ the UN Office of the High

¹ <http://www.palmcenter.org/publication/re-thinking-genital-surgeries-intersex-infants/>

² The Committee on Bioethics of the Council of Europe, “The Rights of Children in Biomedicine: Challenges Posed by Scientific Advances and Uncertainties,” Council of Europe, January 16, 2017, <http://www.coe.int/en/web/children/-/studyon-the-rights-of-children-in-biomedicine>.

³ http://www.who.int/reproductivehealth/publications/gender_rights/eliminating-forced-sterilization/en/



Commissioner for Human Rights,⁴ and organizations of intersex people and parents of intersex children in the US and around the world.⁵

In addition to the mounting health expert and medical ethics consensus that non-necessary surgeries should be deferred until consent can be given by the patients themselves, we support the analysis shared by the UN Special Rapporteur on the right to health; the UN Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment; the UN Special Rapporteur on violence against women, its causes and consequences; the UN Committee on the Rights of the Child; the Special Representative of the United Nations Secretary-General on Violence against Children; the UN Committee against Torture; the UN Committee on the Rights of Persons with Disabilities; the UN Committee on the Elimination of Discrimination against Women; the UN Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment; and the Inter-American Commission on Human Rights that medically unnecessary surgeries conducted on children with intersex traits before they are old enough to provide informed consent amount to a human rights violation and have no place in modern medicine.

I note that the debate over these early surgeries has been going on within medicine for quite some time. Indeed the 2006 “Consensus Statement on Management of Intersex Disorders” and its 2016 update both acknowledge the controversy and the lack of evidence supporting early surgical interventions being a treatment option. I worry that without clear guidance from medical bodies such as the AMA, we will be having similar unproductive discussions a decade from now as well.

I am encouraged that medical sub-specialty organizations on the front lines of providing care for children affected by DSD are developing policies that support the patient’s autonomy, human rights, and best outcomes. This includes the 2017 position statement by the North American Society for Pediatric and Adolescent Gynecology, which received an endorsement from the Pediatric Endocrine Society. It reads:

We believe in respecting the autonomy of the individual patient as well as providing ample support and guidance for the patient and family. All parents and affected patients should be actively encouraged to seek psychological counseling and peer support given the stress, confusion, and isolation that many experience. We believe that surgery alone does not address all the implications associated with DSD conditions. Some DSD conditions require early surgical intervention to optimize health and fertility. Ideally, if surgical interventions could be safely delayed, patients would have time to express their gender identity and to be actively involved in the decision making process. True informed consent or assent includes an accurate discussion of the options, benefits, known short and long term complications, expected pain and recovery, as well as need for reoperation. Finally, we believe that if there is a possibility for fertility, that this should be preserved and optimized.⁶

While I understand that medical protocols have evolved in recent decades, and that the use of multi-disciplinary teams, including endocrinologists, gynecologists, urologists, and psychologists to work on intersex cases is increasingly common, the field remains fraught with uneven,

⁴ United Nations High Commissioner for Human Rights report A/HRC/29/23 (2015)

⁵ <http://aisdsd.org/wp-content/uploads/2017/07/20170725-HRW-AISDSD-Press-Release.pdf>;
https://docs.google.com/document/u/1/d/16skW1o_ISP5pidq9WUVcttJNgndO88W5cMZw3YwB3qc/pub?embedded=true (Intersex Awareness Day Resolution signed by over twenty international intersex-led organizations).

⁶ http://c.ymcdn.com/sites/www.naspag.org/resource/resmgr/pdf's/NASPAG_Statement_on_DSD_PES_.pdf



inadequate, and piecemeal standards of care. This leaves children with intersex traits, their families, and their physicians vulnerable.

Accordingly, Physicians for Human Rights urges the AMA Council on Ethical and Judicial Affairs to adopt a policy to respect and uphold the fundamental human rights of intersex children and adults to health, to physical and mental integrity, to live free from violence and harmful practices and to be free from torture and ill-treatment, and to implement the urgent measures my mandate and other United Nations and regional experts have made in this regard.

Sincerely,

Homer Venters, MD, MS
Director of Programs
Physicians for Human Rights

CC:

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Dr. Scott Chalet, LGBTQ Advisory Board Chair: Scott Chalet scottchalet@yahoo.com



Dennis S. Agliano, MD, FACS
Chair, Council on Ethical and Judicial Affairs

American Medical Association
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330 N. Wabash Ave., Suite 39300 Chicago, IL
60611-5885

February 21, 2018

Dear Dr. Agliano:

I am writing on behalf of Amnesty International USA, which conducts research, training, and advocacy to combat human rights abuses, including those based on sex or gender identity. As the AMA's Council on Ethical and Judicial Affairs considers policy protecting intersex children and ensuring that they are able to meaningfully participate in decisions about their own health, we urge you to support the AMA Board of Trustees Recommendation in report 7-1-16, in favor of multidisciplinary and individualized care for DSD.

Children and youth born with variations of sex characteristics, intersex traits, or differences of sex development (DSD), face challenges and abuses within healthcare systems that are just beginning to be recognized. An estimated 1.7% of children in the world are born every year with variations of sex characteristics, and many of these children as a consequence face medicalization of their identities and interventions that aim to “normalize” and “fix” them that can result in long term trauma.¹ The recommendations of the AMA Board of Trustees uphold a standard of care that should be available to all children,

Optimal management of DSD through individualized, multidisciplinary care:

- (1) seeks to foster the well-being of the child and the adult they will become;*
- (2) respects the rights of the patient to participate in decisions and, except when life-threatening circumstances require emergency intervention, defers medical or surgical intervention until the child is able to participate in decision making; and*
- (3) provides psychosocial support to promote patient and family well-being.*

These standards of care must be specifically affirmed because individuals with variations of sex characteristics have, in the United States as well as globally, been subjected to systematic abuse within medicine. In May 2017, Amnesty International published “First, Do No Harm: Ensuring

¹ Anne Fausto-Sterling, *Sexing the Body*, 2000, (hereinafter: Fausto-Sterling, 2000), p. 53



the Rights of Children with Variations of Sex Characteristics in Denmark and Germany.”² Over two years, we interviewed 16 individuals with variations of sex characteristics in Denmark and Germany, eight parents of children born with these variations, 15 intersex activists in Europe, and 31 medical and health professionals in European countries, in order to understand the effects of “normalizing” surgeries. We found that individuals experienced long-term negative physical or mental difficulties as consequences of these surgeries. Parents of children with variations of sex characteristics that Amnesty International interviewed report that they were provided with insufficient information to enable them to make an informed decision about medical interventions proposed for their children.

Our findings have been parallel to those in the Human Rights Watch report, “I Want to Be Like Nature Made Me: Medically Unnecessary Surgeries on Intersex Children in the US,” which documents medically unnecessary surgeries in the United States. While the negative impacts of medically unnecessary surgeries have been well documented, there are significant gaps in research on the wellbeing of intersex people, or the relative merits of intervention or non-intervention.³ For decades, intersex children have suffered trauma after trauma, often beginning in infancy, in medical settings where they should be safest. In clinics across the United States, intersex infants, sometimes merely months old, are subjected to medically unnecessary surgeries that aim to bring their bodies into conformity with the sex assigned by doctors – a dangerous procedure with no guarantee of affirming a child’s gender later in life. The physical risks and poor outcomes of these childhood surgeries are well documented,⁴ but we have found equally dire and long term psychological impacts of the procedures.

Gender stereotypes have historically driven the current paradigm of care for intersex children. Rationales for surgery on intersex children include the assertion having a vagina is so important that it should be constructed even before the child has the capacity to understand the various functions of that organ⁵; (without knowing whether the individual will have any interest in later using a vagina for penetrative sex, for example). Some proponents of early surgery also say that not performing surgery risks leaving the child confused about their sex or gender identity⁶; (as if

² Amnesty International, “First, Do No Harm: Ensuring the Rights of Children with Variations of Sex Characteristics in Denmark and Germany,” May 9, 2017, <https://www.amnesty.org/en/documents/eur01/6086/2017/en/>.

³ Amnesty International, “First, Do No Harm: Ensuring the Rights of Children with Variations of Sex Characteristics in Denmark and Germany,” May 9, 2017, <https://www.amnesty.org/en/documents/eur01/6086/2017/en/>.

⁴ Peter Lee et al., Review of Recent Outcome Data of Disorders of Sex Development (DSD): Emphasis on Surgical and Sexual Outcomes, *Journal of Pediatric Urology* (2012), available at <http://dx.doi.org/10.1016/j.jpuro.2012.10.017>; Sarah Creighton et al., Objective Cosmetic and Anatomical Outcomes at Adolescence of Feminising Surgery for Ambiguous Genitalia Done in Childhood, 358 *The Lancet* 124 (2001); N.S. Crouch et al., Sexual Function and Genital Sensitivity Following Feminizing Genitoplasty for Congenital Adrenal Hyperplasia, 179 *Journal of Urology* 634 (2008); C.L. Minto et al., The Effects of Clitoral Surgery on Sexual Outcome in Individuals who have Intersex Conditions with Ambiguous Genitalia: A Cross-Sectional Study, 361 *The Lancet* 1252 (2003).

⁵ Sarah Creighton et al., “Timing and nature of reconstructive surgery for disorders of sex development,” *Journal of Pediatric Urology*, 8(6): 602-10 (2012); Martin Kaefer, Richard C. Rink, “Treatment of the Enlarged Clitoris,” *Frontiers in Pediatrics*, 28 August 2017, <http://journal.frontiersin.org/article/10.3389/fped.2017.00125/full>.

⁶ P. Mouriquand et al., “The ESPU/SPU standpoint on the surgical management of disorders of sex development (DSD),” *Journal of Pediatric Urology* 10(1): 8-10 (2014).



surgery can make this possibility of gender dysphoria go away). Published articles have also asserted that girls with large clitorises will be lesbians or will fail to be feminine enough,⁷ and that boys who cannot stand to urinate are not “real boys” at all.⁸ These justifications are based on deeply ingrained gender stereotypes rather than the lived experiences of intersex individuals. The physical risks and poor outcomes of these childhood surgeries are well documented,⁹ and we have found equally dire and long term psychological impacts of the procedures.”¹⁰

While it is understandable for parents and doctors alike to want to improve the lives of the youth for which they care, these interventions are clearly misguided.

Despite claims based on “common sense” that growing up with atypical sex characteristics will adversely impact a child’s mental and emotional well-being, there is no evidence for this proposition – and in fact, intersex children, like all minority children, who receive support from their families and care providers thrive. What is demonstrated in medical evidence to cause harm is the practice of non-emergency, invasive and irreversible surgery with harmful effects, and that survivors of these surgeries experience depression, PTSD, and suicidality¹¹ comparable to survivors of childhood sexual abuse.¹² In addition, some intersex people end up not identifying with the sex assignment they are given as children¹³ – and if surgery was performed to enforce that assignment, this can be deeply distressing, especially when it limits options for other gender-affirming procedures that might be desired when they become consenting adolescents and adults.

The American Academy of Pediatrics affirmed over 20 years ago the importance of protecting

⁷ Sarah Creighton et al., “Timing and nature of reconstructive surgery for disorders of sex development,” *Journal of Pediatric Urology*, 8(6): 602-10 (2012); Martin Kaefer, Richard C. Rink, “Treatment of the Enlarged Clitoris,” *Frontiers in Pediatrics*, 28 August 2017, <http://journal.frontiersin.org/article/10.3389/fped.2017.00125/full>.

⁸ Hazel Glen Beh and Milton Diamond, “An emerging ethical and medical dilemma: should physicians perform sex assignment surgery on infants with ambiguous genitalia?” *Michigan Journal of Gender & Law*, 7(1): 1-63 (2000); Creighton et al., *supra* note 4.

⁹ Peter Lee et al., Review of Recent Outcome Data of Disorders of Sex Development (DSD): Emphasis on Surgical and Sexual Outcomes, *Journal of Pediatric Urology* (2012), available at <http://dx.doi.org/10.1016/j.jpuro.2012.10.017>; Sarah Creighton et al., Objective Cosmetic and Anatomical Outcomes at Adolescence of Feminising Surgery for Ambiguous Genitalia Done in Childhood, 358 *The Lancet* 124 (2001); N.S. Crouch et al., Sexual Function and Genital Sensitivity Following Feminizing Genitoplasty for Congenital Adrenal Hyperplasia, 179 *Journal of Urology* 634 (2008); C.L. Minto et al., The Effects of Clitoral Surgery on Sexual Outcome in Individuals who have Intersex Conditions with Ambiguous Genitalia: A Cross-Sectional Study, 361 *The Lancet* 1252 (2003).

¹⁰ Amnesty International, “First, Do No Harm: Ensuring the Rights of Children with Variations of Sex Characteristics in Denmark and Germany,” May 9, 2017, <https://www.amnesty.org/en/documents/eur01/6086/2017/en/>

¹¹ Marcus de Maria Arana, A Human Rights Investigation into the Medical “Normalization” of Intersex People: A Report of a Public Hearing by the Human Rights Commission of the City and County of San Francisco (April 28, 2005), available at http://sfhrc.org/site/uploadedfiles/sfhumanrights/Committee_Meetings/Lesbian_Gay_Bisexual_Transgender/HRC%20Intersex%20Report.pdf; Schützmann et al. (2009), Psychological distress, suicidal tendencies, and self-harming behaviour in adult persons with different forms of intersexuality, *Arch Sex Behav.* 2009 Feb;38(1):16-33.

¹² Tamara Alexander, *The Medical Management of Intersexed Children: An Analogue for Childhood Sexual Abuse* (1997), available at <http://www.isna.org/articles/analogue>.

¹³ Ieuan Hughes et al., Consensus Statement on Management of Intersex Disorders, 91 *Archives of Disease in Childhood* 554 (2006); P.S. Furtado et al., Gender Dysphoria Associated with Disorders of Sex Development, *Nat. Rev. Urol.* (9 October 2012), available at: [doi:10.1038/nrurol.2012.182](https://doi.org/10.1038/nrurol.2012.182); A. Binet et al., Should We Question Early Feminizing Genitoplasty for Patients with Congenital Adrenal Hyperplasia and XX Karyotype?, *Journal of Pediatric Surgery* 51:3: 465-468 (2016).



children's "developing autonomy."¹⁴ For intersex children, autonomy should include the right to make choices on what is done to their bodies as consenting adults. Intersex children are entitled to a model of care that prioritizes their well-being rather than discriminatory gender binaries. Almost all intersex children are born healthy and with no need for surgery on their genitals or reproductive organs, and these surgeries should be delayed except in emergency situations. Performing surgeries that are invasive, irreversible and performed not for emergency reasons but to 'normalise' a child's body – such as cutting down the size of a "large" clitoris, removing potentially fertile and hormone-producing gonads, or creating a vagina in a child who may never want or need one – is a violation of the child's rights to bodily integrity, to the highest attainable standard of health, and to be free from harmful practices based on gender stereotypes. The American Medical Association is in a position where it has the opportunity be a leader for its member physicians and for the patients that they care for.

It is the strongly held position of Amnesty International that intersex rights are human rights; and that intersex children deserve, as all children do, to meaningfully participate in choices about their body, health, and self. We urge you to act in support of intersex human rights defenders who have worked to end discrimination against intersex individuals, and in support of the highest attainable standard of health for intersex persons.

Sincerely,

Tarah Demant
Director
Gender, Sexuality, and Identity Program
Amnesty International USA
600 Pennsylvania Avenue SE, Washington, DC

CC: Elliott Crigger, PhD, CEJA Secretary, AMA
Craig Johnson, Minority Affairs Section, AMA
Scott Chalet, LGBTQ Section Chair, AMA
CEJA members

¹⁴ AAP Committee on Bioethics, "Informed Consent, Parental Permission, and Assent in Pediatric Practice," *Pediatrics* 95(2):314-17



January 31, 2018

Dennis S. Agliano, MD, FACS
Chair
American Medical Association
Council on Ethical Judicial Affairs
AMA Plaza
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Chicago, IL 60611-5885

Dear Dr. Agliano:

We understand that the American Medical Association (AMA) Council on Ethical and Judicial Affairs (CEJA), which you chair, is currently considering a policy regarding intersex people/people affected by differences of sex development (DSD). I am aware that the AMA Board of Trustees in 2016 recommended a course of action, which prompted review by the CEJA.

As you may know, GLSEN is the leading national education organization working to create safe and affirming schools for all students, regardless of sexual orientation, gender identity, or gender expression. Our work includes a biennial survey of secondary schools students assessing school climate for lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ) youth, programmatic support for students and educators across the country, a chapter network of volunteers in 26 states, and public policy advocacy at all levels of government. Since our founding in 1990, GLSEN has become a globally-recognized leader on school climate and culture.

We know that not all intersex young people identify as LGBTQ, but many certainly do. Decisions made by surgeons have longstanding consequences on these youth. We believe that the common rationale for performing medically-unnecessary surgery on intersex youth – particularly those who are subjected to surgery before even being able to walk or talkⁱ – is often rooted in sex stereotypes and serves no necessary purpose.^{ii,iii} We also believe that other lines of rationale, such as the notion that *not* performing surgery will leave the child confused about their gender,^{iv} is rooted in antiquated conceptions of gender identity development and limits the ability of young people to express their gender freely.

While it is understandable for parents and doctors to want to improve the lives of the young people they care for, medically-unnecessary surgery to “normalize” the bodies of intersex children is misguided. Indeed, making these decisions for young people is reminiscent of sexual orientation change efforts, often called “conversion therapy,” being applied to young LGB youth – efforts which have been shown to be deeply harmful, in addition to ineffective.

Intersex children, like LGBTQ children, can thrive without medical intervention if they receive social support from their families and care providers. There are no known negative psychological outcomes associated with simply being intersex, despite the baseless argument that growing up with atypical sex characteristics will adversely impact a child’s mental and emotional health. Harm, however, is caused by the practice of non-consensual, medically-unnecessary surgery. Studies have found that intersex people who have been subjected to these surgeries experience depression, PTSD, and suicidality^v and carry trauma comparable to survivors of childhood sexual abuse.^{vi} Additionally, research has found that many intersex people end up identifying with a gender that is different than the sex they were assigned as children.^{vii} Performing surgery that reinforces

that assignment can be deeply distressing and may hinder options available for gender transition when they become consenting adults.

By adopting a position opposing medically-unnecessary surgeries on intersex children and youth, the AMA would be acting in concert with leading international organizations. The United Nations Human Rights Council has determined that nonconsensual genital “normalizing” surgery on intersex children is a form of ill-treatment, and the World Health Organization has publicly opposed early genital or sterilizing surgeries on intersex youth.

GLSEN urges the AMA to pass and implement a policy in favor of respecting the autonomy of pediatric patients with DSD, including clear guidance that, unless medically necessary, no surgeries should be performed on the intersex child until they are old enough to give informed consent for the procedures. We thank you for your attention and consideration of this important issue. For additional information or to discuss further, please contact Nathan Smith, GLSEN's Director of Public Policy, at nathan.smith@glsen.org or by phone at (202) 621-5815.

Sincerely,



Eliza Byard, Ph.D.
Executive Director

CC David O. Barbe, MD, MHA, President, American Medical Association
Elliott Crigger, CEJA Director
Craig Johnson, Minority Affairs Section Director
Scott Chaiet, LGBTQ Advisory Board Chair

ⁱ Sarah Creighton and Lih-Meh Liao, “Changing attitudes to sex assignment in intersex,” *BJU International* 93: 659-64 (2004).

ⁱⁱ Sarah Creighton et al., “Timing and nature of reconstructive surgery for disorders of sex development,” *Journal of Pediatric Urology*, 8(6): 602-10 (2012); Martin Kaefer, Richard C. Rink, “Treatment of the Enlarged Clitoris,” *Frontiers in Pediatrics*, 28 August 2017, <http://journal.frontiersin.org/article/10.3389/fped.2017.00125/full>.

ⁱⁱⁱ Hazel Glen Beh and Milton Diamond, “An emerging ethical and medical dilemma: should physicians perform sex assignment surgery on infants with ambiguous genitalia?” *Michigan Journal of Gender & Law*, 7(1): 1-63 (2000); Creighton et al., *supra* note 4.

^{iv} P. Mouriquand et al., “The ESPU/SPU standpoint on the surgical management of disorders of sex development (DSD),” *Journal of Pediatric Urology* 10(1): 8-10 (2014).

^v Marcus de Maria Arana, *A Human Rights Investigation into the Medical “Normalization” of Intersex People: A Report of a Public Hearing by the Human Rights Commission of the City and County of San Francisco* (April 28, 2005), available at http://sfhrc.org/site/uploadedfiles/sfhumanrights/Committee_Meetings/Lesbian_Gay_Bisexual_Transgender/HRC%20Intersex%20Report.pdf; Schützmann et al. (2009), Psychological distress, suicidal tendencies, and self-harming behaviour in adult persons with different forms of intersexuality, *Arch Sex Behav*. 2009 Feb;38(1):16-33.

^{vi} Tamara Alexander, *The Medical Management of Intersexed Children: An Analogue for Childhood Sexual Abuse* (1997), available at <http://www.isna.org/articles/analogue>.

^{vii} Ieuan Hughes et al., *Consensus Statement on Management of Intersex Disorders*, 91 Archives of Disease in Childhood 554 (2006); P.S. Furtado et al., *Gender Dysphoria Associated with Disorders of Sex Development*, *Nat. Rev. Urol.* (9 October 2012), available at: doi:10.1038/nrurol.2012.182; A. Binet et al., *Should We Question Early Feminizing Genitoplasty for Patients with Congenital Adrenal Hyperplasia and XX Karyotype?*, *Journal of Pediatric Surgery* 51:3: 465-468 (2016).

February 15, 2018
Dennis S. Agliano, MD, FACS
Chair, Council on Ethical and Judicial Affairs
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Dear Dr. Agliano:

At the 2016 AMA Annual Meeting of the House of Delegates, the Medical Student Section introduced a resolution entitled “Supporting Autonomy for Patients with Differences of Sex Development,” which asked that our AMA affirm that medically unnecessary surgeries in individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making. The House of Delegates referred this resolution for study, and the Board of Trustees returned a report at the Interim 2016 House of Delegates that was likewise referred for study. The issue then came before the Council on Ethical and Judicial Affairs; CEJA Report 3 at Interim 2017 was also referred. As the author of the original resolution that led to Council on Ethics and Judicial Affairs Report 3-I-17, the Medical Student Section is grateful for the opportunity to offer additional information and updated literature for the Council’s consideration.

As the Council heard at the Reference Committee hearing, the Medical Student Section was concerned that the Interim 2017 report did not directly address care for the population of patients with differences of sex development (DSD). A main goal of the original resolution was to address the issue of surgeries performed on this population in early infancy for the purpose of normalizing the cosmetic appearance of genitalia and/or to define patient gender, such as clitoroplasty, vaginoplasty, labiaplasty, and gonadectomy. Such surgeries have unique implications for issues of sex/gender identity, sexual orientation, procreative potential, and sexual function, each of which we believe intrinsically merits discussion. We were heartened that the Council recognized the integral role that physicians play in influencing parental decision-making for these patients, as illuminated by Streuli et al. Also noted by the Council was the lack of unanimous opinion or definitive evidence surrounding of the timing of genital surgeries for these patients, as discussed by Machado et al. In light of these considerations, we believe the Council should support the autonomy of patients with DSD by encouraging physicians to postpone cosmetic and genital-normalizing surgeries.

We believe physicians should offer optimized multi-disciplinary management for patients with differences of sex development that provides psychosocial support for both children and families, respects the rights of the patient to participate in decisions, and, except when medically necessary, defers surgical intervention for the purpose of genital normalizing until the child is able to participate in decision making. Multiple patient advocacy and medical groups have rejected early genital surgery, and instead promote multidisciplinary care and peer support similar to that which we see for a range of congenital conditions. In no way are we proposing a complete ban on cosmetic genital surgery, but that these surgeries are delayed until the child can be involved in decision-making.

Proponents of early surgery point to limited studies with adult patients who favor earlier surgery, and to a perceived greater psychological impact of late genital surgery. The studies often cited to support this position compare early versus late surgery, but do not examine outcomes of patients who did not receive surgery at all. In fact, there is a growing body of evidence that individuals with DSD who delay or do not

undergo surgery do not suffer additional harm as a result. Ultimately, there is a significant lack of definitive evidence to support the timing of surgery or decision to undergo surgery. Although the proposed concerns merit attention, we do not feel that they justify the practice of medically unnecessary treatment and surgery without consent in light of documented physical and psychological harm from these procedures. The potential psychological harm associated with delayed surgery can be addressed, while adverse outcomes of irreversible surgical intervention cannot be undone.

In the supporting materials attached to this letter, we have provided several additional arguments and literature in support of deferral.

Thank you for your consideration of these materials, and for taking on this important issue. We would be happy to offer any other information that may assist the Council in its deliberations.

Sincerely,

American Medical Association - Medical Student Section
Jerome Jeevarajan, Delegate
Kieran McAvoy, Alternate Delegate

CC:

Elliott Crigger, PhD, CEJA Secretary, AMA
Craig Johnson, Minority Affairs Section, AMA
Scott Chalet, MD, MBA, FACS, LGBTQ Section Chair, AMA

An outline of the argument in support of deferring early surgery, followed by an expanded version with specific literature:

1. Individuals with DSD can do well without early surgery, and early surgery is not necessary to assign gender at birth.
2. There is no medical reason for alteration of the clitoris, vagina, and labia.
3. Early sex assignment surgery performed on genitalia may irreversibly assign the individual a sex incongruent with their actual gender identity, a potentially catastrophic outcome with profound psychological consequences. Notably, some individuals may not identify within the male/female gender binary.
4. Early surgery on genitalia can lead to significant adverse surgical outcomes, including but not limited to loss of sensitivity, orgasmic function, and fertility, as well as chronic pain and dyspareunia. While some or even many individuals may be willing to choose such surgery, infants cannot participate in this decision. The argument that surgery should be done early in life to prevent the psychological impact associated with late surgery does not hold if there are multiple re-operations (as there frequently are) and assumes that all individuals would choose surgery as an inevitable outcome.
5. Between sexual function and cosmetic appearance, what is more important is a highly personal assessment. Ideally, both would be preserved, but in selecting surgery, appearance is often prioritized at the expense of function. Some studies indicate that some individuals would choose function over cosmetic appearance given the choice.
6. As children with atypical genitalia age, they may desire to have genital-normalizing surgery performed, as would be their prerogative. While some proponents argue that it may be easier to perform surgery on children than adults, there are no data from studies comparing this outcome. In addition, it could be argued that outcomes may be better in post-pubertal individuals with estrogenized tissues. Surgery can be performed successfully on adult women with preservation of orgasmic function.
7. Studies reporting that a high percentage of individuals prefer early surgery often do not offer individuals the option to answer the question “Would you have wanted surgery at all?” and do not often include controls with the condition in question that remain unoperated. It is also notable that individuals that are particularly displeased with their medical care may refuse to participate, though the converse may also be true.
8. While individuals with DSD may express distress with regards to their atypical genitalia, it is also quite common for individuals without DSD to experience concern over the appearance of their (“normal”) genitalia. Addressing such cases would begin with psychosocial support, education, attempting to address societal pressures and barriers, and potentially surgery if the individuals so desired. However, in such cases, it is unlikely that surgery would be the initial intervention.
9. A common argument for early intervention is the prevention of stigma with regard to atypical genitalia. However, this does not take into account whether the surgeries to make genitalia appear more typical may also cause stigma. There is no evidence that deferring early surgery causes psychological distress, and there is no evidence that performing early surgery prevents psychological distress. In addition, there is evidence that the medicalization of children with DSD and frequent genital exams contribute to distress and stigma. Finally, psychological distress should be most appropriately managed initially through psychosocial support.
10. Early surgery on genitalia has caused significant distress to many individuals with DSD.
11. Parental desire to avoid difficult decisions, concerns about hypothetical stigma, and concerns about normality should not be the main impetus for surgical management, but rather should be managed with psychosocial support. The following literature implies that parental distress stems

from an inadequate understanding of DSD and the perceived impact on their newborn. Offering psychosocial support that provides a de-medicalized explanation of their baby's genital diversity alleviates this distress and reduces perceived need for early cosmetic surgery. Regardless of the decision to postpone or proceed with surgery at any age, appropriate counseling and support for the individual and family is essential.

12. There are arguments in favor of early surgery to prevent development of malignancy; however, malignancy rates are not uniform across individuals with DSD and risk should be evaluated with respect to their specific condition.
13. Potential for fertility should remain a consideration in decision-making.
14. Early genital surgery for cosmetic purposes subjects children to unjustifiable risks of pediatric anesthetic neurotoxicity.

Expanded argument in support of deferring early surgery with specific literature:

1. Individuals with DSD can do well without early surgery, and early surgery is not necessary to assign gender at birth.
 - a. **Bougneres P, Bouvattier C, Cartigny M, Michala L. Deferring surgical treatment of ambiguous genitalia into adolescence in girls with 21-hydroxylase deficiency: a feasibility study. International Journal of Pediatric Endocrinology. 2017;2017(3). doi: 10.1186/s13633-016-0040-8.** This study is of a small sample size of seven girls up to age 8 with CAH with Prader III-IV stages who have remained unoperated. Results suggest that is “acceptable among patients and families to defer genital operation in [21-hydroxylase deficiency]...[G]irls and their parents have not expressed significant concerns regarding genital ambiguity.” The authors conclude: “With these encouraging data at hand, we propose to formally address levels of anxiety, adaptation and quality of life during childhood, with an ultimate goal to assess long- term satisfaction and effects on sexuality through deferring genital surgery.” This demonstrates that children, even those with 46,XX CAH, can be assigned and raised as a certain gender without surgical intervention. The child is free to develop their own gender identity, and at a later point express their desire for genital surgery if they wish.
 - b. **Callens N, van der Zwan YG, Drop SLS, et al. Do surgical interventions influence psychosexual and cosmetic outcomes in women with disorders of sex development? ISRN Endocrinology. 2012:1-8. doi: 10.5402/2012/276742.**

This is a study performed in Netherlands and Belgium, featuring 33 intersex participants who had not undergone surgeries, which found that women with complete absence of the vagina (e.g., CAIS) demonstrated no psychological or developmental problems until they reached menstruation and concluded vaginal surgery should be deferred until later in life. Construction of a vagina was not necessary for female gender assignment.
2. There is no medical reason for alteration of the clitoris, vagina, and labia.
 - a. **Kaefer M, Rink RC. Treatment of the enlarged clitoris. Frontiers in Pediatrics. 2017;5(125):1-11. doi: 10.3389/fped.2017.00125.** This is a review of current management of clitoromegaly, including discussion of perioperative counseling and the timing of clitoroplasty. With regard to indication for clitoroplasty, the authors comment: “At present, the decision to perform genital surgery in children with clitoromegaly is intensely debated. As with all reconstructive surgery for patients with Disorders of Sex Development (DSD), three specific reasons for intervening are typically considered: providing anatomy suitable for penile-vaginal intercourse, achieving a manner for urination commensurate with gender identity (i.e., sitting for females, standing for males), and providing a phenotypical appearance that resembles the assigned gender. Since the only known function of the clitoris itself is to provide sexual pleasure, the later goal is the only one that is relevant to the discussion of clitoroplasty.”
 - b. **Creighton SM, Michala L, Mushtaq I, Yaron M. Childhood surgery for ambiguous genitalia: glimpses of practice changes or more of the same? Psychology and Sexuality. 2013. doi: 10.1080/19419899.2013.831214.** While a main stated goal of clitoral reduction surgery is a “feminine” appearance, “[t]he size of the clitoris can vary significantly amongst women without a DSD and there is no defined normal range for children.” Because of this, “the [2006] consensus statement recommends no surgery for girls with minor and moderate degrees of clitoral enlargement until they can decide for themselves.” The perception of clitoral size, however, is ultimately subjective: “Some

families cope well with more severe degrees of clitoral enlargement and are keen to postpone surgery. Other families are very distressed by what would appear to clinicians as very minor degrees of clitoral enlargement.” Therefore, on the continuum of clitoral size, which individuals are and are not recommended for reduction surgery depends on the perception of individual doctors and/or caregivers, not defined medical standards.

- c. Wolffebuttel KP, Crouch NS. Timing of feminising surgery in disorders of sex development. In: Hiort O, Ahmed SF, eds. Understanding Differences and Disorders of Sex Development (DSD). Endoc Dev. Basel, Karger; 2014;27:210-221: “Vaginal surgery may be indicated either to allow unobstructed menstrual flow, such as for those with CAH, or to develop a vagina suitable for intercourse for those with vaginal hypoplasia. Where there is no uterus and no risk to obstructed menstrual flow, the only indication for the development of a vagina is when the girl is ready to become sexually active. A child has no need of a vagina, and the timing can appropriately be deferred until adolescence.”**
3. Early sex assignment surgery performed on genitalia may irreversibly assign the individual a sex incongruent with their actual gender identity, a potentially catastrophic outcome with profound psychological consequences. Notably, some individuals may not identify within the male/female gender binary.
 - a. Furtado PS, Moraes F, Lago R, et al. Gender dysphoria associated with disorders of sex development. Nature Reviews Urology. 2012;9:620-627. doi:10.1038/nrurol.2012.182.** Gender dysphoria is reported in approximately 5% of individuals with complete androgen insensitivity syndrome; 10% of individuals with congenital adrenal hyperplasia; 12.5% of individuals with ovotesticular DSD; 20% of individuals with partial androgen insensitivity syndrome; 29% of individuals with mixed gonadal dysgenesis; 39% of individuals with cloacal exstrophy; 57% of individuals with 17-beta-hydroxysteroid dehydrogenase deficiency; and 63% of individuals with 5-alpha-reductase deficiency.
 - b. Lee PA, Houk CP, Ahmed SF, Hughes IA. Consensus statement on management of intersex disorders. Pediatrics. 2006;118(2):e488-e500. doi:10.1542/peds.2006-0738.** Rates of gender assignment rejection reach approximately 10% for individuals with congenital adrenal hyperplasia; 25% for individuals with partial androgen insensitivity syndrome, androgen biosynthetic defects, and incomplete gonadal dysgenesis; 35% for individuals with cloacal exstrophy; and 60% for individuals with 5-alpha-reductase deficiency.
 - c. Schweizer K, Brunner F, Handforda C, Richter-Appelt H. Gender experience and satisfaction with gender allocation in adults with diverse intersex conditions (divergences of sex development, DSD). Psychology & Sexuality. 2013.** Of the 69 participants, 26% felt uncertain about belonging to a specific binary gender category.
4. Early surgery on genitalia can lead to significant adverse surgical outcomes, including but not limited to loss of sensitivity, orgasmic function, and fertility, as well as chronic pain and dyspareunia. While some or even many individuals may be willing to choose such surgery, infants cannot participate in this decision. The argument that surgery should be done early in life to prevent the psychological impact associated with late surgery does not hold if there are multiple re-operations (as there frequently are) and assumes that all individuals would choose surgery as an inevitable outcome.

- a. **Lee P, Schober J, Nordenström A, et al. Review of recent outcome data of disorders of sex development (DSD): emphasis on surgical and sexual outcomes. Journal of Pediatric Urology. 2012;8(6):611–615. doi: <https://doi.org/10.1016/j.jpuro.2012.10.017>** In one study, among “57 46,XY DSD adults who had undergone genital surgery, 47.1% were dissatisfied with functional results, 47.4% with clitoral arousal and 37.5% with overall sex life; 44.2% had sexual anxieties, 70.6% had problems with desire and 56.3% reported dyspareunia.”
- b. **Minto CL, Liao LM, Woodhouse CR, et al. The effect of clitoral surgery on sexual outcome in individuals who have intersex conditions with ambiguous genitalia: a cross-sectional study. Lancet. 2003;361(9365):1252-7. doi: 10.1016/S0140-6736(03)12980-7:** Of 39 intersex adults living as female, all 28 who were sexually active had sexual difficulties. 18 who had undergone clitoral surgery had higher rates of non-sensuality (78%) and of inability to achieve orgasm (39%) than the 10 who did not (20% and 0%).
- c. **Creighton SM. Long-term outcome of feminization surgery: the London experience. BJU International. 2004;93(3):44-46:** “Any incision to the clitoral glans, corpora or hood may risk damage to the innervation. . . .Those who had undergone clitoral surgery were significantly less likely to achieve orgasm than those who had not had surgery (26% anorgasmia vs 0%, respectively). . . .The study suggests that cosmetic surgery to the clitoris does not ensure improved adult sexual function and indeed might cause damage.”
- d. **Crouch NS, Minto CL, Liao LM, et al. Genital sensation after feminizing genitoplasty for congenital adrenal hyperplasia: a pilot study. BJU International. 2003;93(1):135-8. doi: 10.1111/j.1464-410X.2004.04572.x** In a sample of six women with CAH who had previously undergone surgery, all six were found to have “highly abnormal” results for sensation in the clitoris following thermal, vibratory, and light-touch sensory threshold assessment. Results for the unoperated upper vagina were within the normal range.
- e. **Nordenskjöld A, Holmdahl G, Frisen L, et al. Type of mutation and surgical procedure affect long-term quality of life for women with congenital adrenal hyperplasia. Clin Endocrinol Metab 2008;93:380–386:** There were 62 women with CAH studied. Of the 49 women with CAH who had surgery, 16 had only one procedure, and of these, 10 had the operation at puberty. 33 of the women had multiple re-operations, with 11 women having five or more surgeries. 20.4% of patients were unhappy with surgery. With regard to cosmetic appearance, “[t]he highest scores were given in the nonoperated group.” Operated women experience reduced sensitivity. Six women stated they never achieved orgasm, with five of the six having clitoral surgery.
- f. **Fagerholm R, Santtila P, Miettinen PJ, Mattila A, Rintala R, Taskinen S. Sexual function and attitudes toward surgery after feminizing genitoplasty. Journal of Urology 2011;185:1900-1904. DOI:10.1016/j.juro.2010.12.099:** 43% of patients who underwent vaginoplasty surgeries in infancy needed re-operations. 54% required vaginal dilations under general anesthesia starting at a median age of 13 years. 58% ended up needing to perform vaginal self-dilations as a result of these surgeries starting at a median age of 17 years (range 14 to 23). Of the 14 patients with vaginal self-dilations 6 (46%) experienced the dilations as distressing. Nearly 1 in 4 patients reported dissatisfaction with genital sensation -- both vaginal and clitoral. The pain index was worse in the patients (especially in the CAH group) than in the controls.

5. Between sexual function and cosmetic appearance, what is more important is a highly personal assessment. Ideally, both would be preserved, but in selecting surgery, appearance is often prioritized at the expense of function. Some studies indicate that some individuals would choose function over cosmetic appearance given the choice.
 - a. **Nordenström A et al. Sexual function and surgical outcome in women with congenital adrenal hyperplasia due to *CYP21A2* deficiency: clinical perspective and the patients' perception. *The Journal of Clinical Endocrinology & Metabolism*. 2010;95(8):3633–3640, <https://doi.org/10.1210/jc.2009-2639>:** “Our study shows that the sexual function score, but not the score for genital appearance, was higher in the patients satisfied with their sexual life and in the patients who stated that they were satisfied with the surgical result. This confirms that function should be of higher priority than genital appearance in treatment decisions.”
6. As children with atypical genitalia age, they may desire to have genital-normalizing surgery performed, as would be their prerogative. While some proponents argue that it may be easier to perform surgery on children than adults, there are no data from studies comparing this outcome. In addition, it could be argued that outcomes may be better in post-pubertal individuals with estrogenized tissues. Surgery can be performed successfully on adult women with preservation of orgasmic function.
 - a. **Tjalma WW. Assembling a functional clitoris and vulva from a pseudo-penis: a surgical technique for an adult woman with congenital adrenal hyperplasia. *Journal of Pediatric and Adolescent Gynecology*. 2017;30:425e428:** This is a case report of a woman with CAH who underwent a corpora-preserving clitoroplasty as an adult. The author states this technique is typically used in children, and there may need to be removal of the corpora cavernosa and recurrent procedures. In this case, due to the patient's age, she was able to have a single-stage procedure and preservation of the corpora cavernosa. At the patient's 6 year follow-up, she remained able to orgasm and had a good cosmetic result. While this is a solely a case report, it does demonstrate the feasibility of delaying surgery, with arguably better results in adulthood.
7. Studies reporting that a high percentage of individuals prefer early surgery often do not offer individuals the option to answer the question “Would you have wanted surgery at all?” and do not often include controls with the condition in question that remain unoperated. It is also notable that individuals that are particularly displeased with their medical care may refuse to participate, though the converse may also be true.
 - a. **Nordenskjöld et al.** 20 of the women surveyed preferred early timing of surgery, while 9 preferred surgery at puberty; however, the opinions of the remaining 33 women are not indicated. It is possible these 33 women would have preferred no surgery at all if given the option.
 - b. **Wisniewski AB, Migeon CJ, Malouf MA, Gearhart JP. Psychosexual outcome in women affected by congenital adrenal hyperplasia due to 21-hydroxylase deficiency. *Journal of Urology*. 2004;171:2497–2501:** When asked about the optimal timing for surgery, 31% of the simple virilizing (SV) group and 41% in the salt-losing group, responded “during infancy,” a minority response. However, 31% of participants in the SV group did not answer -- the same number as answered that the optimal timing was during infancy. Participants were not asked if they would rather not have had surgery at all. From this, it would be misleading to conclude that patients surveyed felt the optimal timing was during infancy.

- c. **Binet A, Harty H, Geslin D, Francois C, Poli-Merol ML. Should we question early feminizing genitoplasty for patients with congenital adrenal hyperplasia? Journal of Pediatric Surgery. 2016;51:465-468:** The sample was divided into early and late surgery groups, with age-matched controls. However, there was no control group of intersex individuals who did not have surgery. While 90% of CAH patients responded that genitoplasty should be performed during the first year of life, there was no response option for patients who would not want to have surgery at all.
 - d. **Fagerholm et al.** While the authors state 17 of 24 patients thought that genital surgery was performed at a proper age (infancy), notably the outreach for this original survey yielded a 50% response rate, meaning it is possible that only those who were happy with their surgical outcomes volunteered to participate in the research. The authors failed to take into account respondents who did not want surgery at all, with the only opportunity to indicate this being the last response option on a question about timing of surgery (“Was the genital surgery done at the proper age?”), which may lead respondents to believe genital surgery was an inevitable part of treatment. Regardless, two patients reported believing that their surgery should not have been done at all.
8. While individuals with DSD may express distress with regards to their atypical genitalia, it is also quite common for individuals without DSD to experience concern over the appearance of their (“normal”) genitalia. Addressing such cases would begin with psychosocial support, education, attempting to address societal pressures and barriers, and potentially surgery if the individuals so desired. However, in such cases, it is unlikely that surgery would be the initial intervention.
 - a. **Lloyd J, Crouch NS, Minto CL, Liao L-M, Creighton SM. Female genital appearance: ‘normality’ unfolds. BJOG: An International Journal of Obstetrics & Gynaecology. 2005;112:643–646. doi:10.1111/j.1471-0528.2004.00517.x:** This study of 50 women found wide variations in the dimensions and appearance of the external female genitalia measured, expanding the definition of “normal” female genitalia.
 - b. **Schick VR, Calabrese SK, Rima BN, Zucker AN. Genital appearance dissatisfaction: Implications for women's genital image self-consciousness, sexual esteem, sexual satisfaction, and sexual risk. Psychology of Women Quarterly. 2010;34(3):394-404.** There is significant evidence that even women with “normal” genitalia experience concern over the appearance of their genitalia due to societal pressures.
 - c. **Vaginal "rejuvenation" and cosmetic vaginal procedures. ACOG Committee Opinion No. 378. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;110:737–8. And Breast and labial surgery in adolescents. Committee Opinion No. 686. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;129:e17-9.** As ACOG has noted in its own policies, there are wide ranges of “normal” appearances for genitalia, and “surgical alteration of the labia that is not necessary to the health of the adolescent, who is younger than 18 years, is a violation of federal criminal law.”
9. A common argument for early intervention is the prevention of stigma with regard to atypical genitalia. However, this does not take into account whether the surgeries to make genitalia appear more typical may also cause stigma. There is no evidence that deferring early surgery causes

psychological distress, and there is no evidence that performing early surgery prevents psychological distress. In addition, there is evidence that the medicalization of children with DSD and frequent genital exams contribute to distress and stigma. Finally, psychological distress should be most appropriately managed initially through psychosocial support.

- a. **Meyer-Bahlburg HF, Reyes-Portillo JA, Khuri J, Ehrhardt AA, New MI. Syndrome-related stigma in the general social environment as reported by women with classical congenital adrenal hyperplasia. Archives of Sexual Behavior. 2017;46:341–351. doi: 10.1007/s10508-016-0862-8:** “Whether the discovery of having genitals different from those of other girls or women became an adverse experience appeared to depend in part on parental reactions,” suggesting that if parents were counseled appropriately, these negative experiences could be avoided. Stigma was associated with many features not related to genital appearance (such as hirsutism), and “stigma related to genital ambiguity was rarely reported for the specific social contexts [stigma by parents, media, peers] on which the present article is focused.” When stigma is experienced, it does not necessarily follow that the best solution is surgical “normalization” rather than psychosocial support. (Note that the Meyer-Bahlburg et al. articles reference the same group of women, and that their generalizability is limited due to not including a significant number of women with CAH who were unoperated.)
 - b. **Meyer-Bahlburg HF, Khuri JR, et al. Stigma associated with classical congenital adrenal hyperplasia in women’s sexual lives. Archives of Sexual Behavior. 2017.** While 40% of the 62 women reported stigma with respect to romantic/sexual partners, concerns surrounded features (such as hirsutism) that are not addressable by surgery in addition to atypical genitals. While some were happy to have genital surgery, some reports of stigma came from women who had early genital surgery with an unsatisfactory outcome, indicating that early genital surgery does not eliminate experienced stigma.
 - c. **Meyer-Bahlburg HF, Khuri JR, et al. Stigma in medical settings as reported retrospectively by women with congenital adrenal hyperplasia (CAH) for their childhood and adolescence. Journal of Pediatric Psychology. 2016. doi: 10.1093/jpepsy/jsw034:** Of the approximately two-thirds of participating women with CAH who reported stigma experiences, “[a]ccounts pertaining specifically to medical settings were provided by 17 women (27%)...About a quarter of the participating women with CAH reported experiencing the genital examinations in childhood and adolescence as adverse events that contributed to their sense of [stigma].”
 - d. **Callens et al.** Notably, a third of the 91 patients refused a gynecological exam during the study as they had undergone exams that were experienced as shameful. This also raises the question whether “the very approach that was adopted to prevent psychological maladjustment to DSD [genital surgery] is in fact the cause of the high levels of psychological and sexual distress reported.”
10. Early surgery on genitalia has caused significant distress to many individuals with DSD.
- a. **a. Schützmann K, Brinkmann L, Schacht M, Richter-Appelt H. Psychological distress, suicidal tendencies, and self-harming behaviour in adult persons with different forms of intersexuality. Archives of Sexual Behavior 2009;38(1):16-33. doi: 10.1007/s10508-007-9241-9.** In a sample of 37 intersex people (all but one of whom had previously undergone genital surgery, gonadectomy, or both): 59% met the criteria for clinical distress, with a history of gonadectomy significantly linked to increased distress; 46% reported having had suicidal thoughts, again significantly linked to previous

gonadectomy. Suicidal ideation was comparable between intersex respondents and women who had experienced physical or sexual abuse, while rates of self-harming behavior were higher than in women with a history of either kind of abuse.

- b. **The Foundation for Narrative Inquiry in Bioethics. VOICES Personal Stories from the Pages of NIB: Normalizing Intersex. John Hopkins University Press; 2016.** http://narrativebioethics.com/wp-content/uploads/2017/07/Voices_2016_INTERSEX_FINAL.pdf: Multiple personal accounts exist from individuals with DSD who experienced trauma as a result of early surgery.
 - c. **Schweizer K, Brunner F, Gedrose B et al. Coping with diverse sex development: treatment experiences and psychosocial support during childhood and adolescence and adult well-being. Journal of Pediatric Psychology. 2017;42(5):504–519.** <https://doi.org/10.1093/jpepsy/jsw058>: Of the studied 69 participants: 64% had gonadectomy, 55% had genital surgery, of which 44% had repeated surgery. 62% experienced psychological distress; the lifetime prevalence of suicidality was 45%. A history of gonadectomy was correlated with prevalence of suicidal thoughts.
11. Parental desire to avoid difficult decisions, concerns about hypothetical stigma, and concerns about normality should not be the main impetus for surgical management, but rather should be managed with psychosocial support. The following literature implies that parental distress stems from an inadequate understanding of DSD and the perceived impact on their newborn. Offering psychosocial support that provides a de-medicalized explanation of their baby's genital diversity alleviates this distress and reduces perceived need for early cosmetic surgery. Regardless of the decision to postpone or proceed with surgery at any age, appropriate counseling and support for the individual and family is essential.
- a. **Bennecke E, Werner-Rosen K, Thyen U, et al. Subjective need for psychological support (PsySupp) in parents of children and adolescents with disorders of sex development (dsd). European Journal of Pediatrics. 2015;174(10):1287-97. doi: 10.1007/s00431-015-2530-8.** "Our data show that sex assignment surgery neither reduces nor increases the need for [psychological support] in parents. **Schober argues that surgery makes parents and doctors more comfortable, but counselling makes people comfortable too, and it is not irreversible.** As surgery does not reduce the need for [psychological support] in parents, the fears and concerns of parents should not be the reasons for sex assignment surgery." Notably, 40% of parents in this study felt they needed psychological support. However, only half of these parents received any support.
 - b. **Tamar-Mattis A, Baratz A, Dalke KB, Karkazis K. Emotionally and cognitively informed consent for clinical care for differences of sex development. Psychology & Sexuality. 2014;5(1):44-55. doi: 10.1080/19419899.2013.831215.** The authors discuss the need for psychosocial support for families to help facilitate processing emotions in order to make informed decisions. They also note that quality peer support and sharing real-life perspectives is "very effective" for parents raising a child with DSD. They also note that "above all, parents must understand that there is no medical or surgical cure for the complex realities of rearing a child who has a physical difference."
 - c. **Binet et al.** The article cites the difficulty of discussing genital surgery with adolescent children as a reason to perform surgery during infancy. While the conversation may be difficult, the solution is to provide adequate counseling and therapy, not to unilaterally perform surgery simply to avoid this conversation.

- d. **Streuli JC, Vayena E, Cavicchia-Balmer Y, Huber J. Shaping parents: impact of contrasting professional counseling on parents' decision making for children with disorders of sex development. Journal of Sexual Medicine. 2013;10(8):1953-60. doi: 10.1111/jsm.12214.** This study assessed parental decision-making using third-year medical students as "parent" subjects. Found that 66% of "parents" chose genitoplasty for their hypothetical child when information was presented in a medicalized way by an endocrinologist, vs. 23% when information was presented in a de-medicalized way by a psychologist. Because the perception and assessment of their child's condition and treatment options can be heavily influenced by providers' framings, not all given parents have an inevitable preference for surgery. Management of parents' emotional and decision-making processes may pre-empt any desire for irreversible surgery on the child.
 - e. **Dayner JE, Lee PA and Houk CP. Medical treatment of intersex: Parental Perspectives. 2004;172:1762–1765. doi: 10.1097/01.ju.0000138519.12573.3a:** This study focuses on 21 parents of children with CAH and atypical genitalia, relying solely on parental perception of child genital appearance as an indicator of successful outcomes. All of the parents were advised by physicians to consent to genital surgery during their child's infancy, and 89% did consent. 95% of parents indicated that they would consent to genital surgery even if a reduction in their child's sexual sensation or responsiveness were certain, disregarding their children's potential prioritization of sensation over appearance. The study asserts that "[m]any parents related that the physical and psychological benefits of surgery in infancy permitted a more normal childhood by avoiding ostracism from others," but this claim has never been demonstrated in literature. No intersex patients were interviewed.
12. There are arguments in favor of early surgery to prevent development of malignancy; however, malignancy rates are not uniform across individuals with DSD and risk should be evaluated with respect to their specific condition.
- a. **Spoor JA, Oosterhuis JW, Hersmus R, et al. Histological assessment of gonads in DSD: relevance for clinical management. Sex Development. 2017. doi:10.1159/000481757:** "In DSD, the malignancy risk is highly heterogeneous, but recent studies allow now to discriminate between high- and low-risk conditions."
 - b. **Lee PA, Houk CP, Ahmed SF, Hughes IA. Consensus statement on management of intersex disorders. Pediatrics. 2006;118(2), e488-e500. doi:10.1542/peds.2006-0738:** Lee et al provides further examples of the heterogeneity of patients who fall under the DSD umbrella. Patients with complete androgen insensitivity syndrome (CAIS) can defer surgery until adolescence, "recognizing that the earliest reported malignancy in CAIS is at 14 years of age." The risk of malignancy in a patient with mixed gonadal dysgenesis or streak gonads may justify earlier removal as a matter of medical necessity.
 - c. **Abacı A, Çathı G, Berberoğlu M. Gonadal malignancy risk and prophylactic gonadectomy in disorders of sexual development. 2015;28(9-10):1019-27. doi:10.1515/jpem-2014-0522:** "In the past, early gonadectomy was recommended for all cases of 46,XY DSD, however, according to current approaches, gonadal tumor risk is predicted based on the molecular diagnosis and the timing of the gonadectomy depends on the result of molecular analysis."
 - d. **Huang H, Wang C, Tian Q. Gonadal tumour risk in 292 phenotypic female patients with disorders of sex development containing Y chromosome or Y-derived sequence.**

Clinical Endocrinology Oxford. 2017;86(4):621-627. doi: 10.1111/cen.13255: The authors conclude that with monitoring and close follow-up, patients with AIS could postpone bilateral gonadectomy until or after adolescence.

13. Potential for fertility should remain a consideration in decision-making.
 - a. **Finlayson C, Fritsch MK, Johnson EK, et al. Presence of germ cells in disorders of sex development: Implications for fertility potential and preservation. The Journal of Urology. 2017;197(3):937-943.** “Germ cells were present in the majority of our cohort and the presence decreased with age. This novel, fertility driven evaluation of germ cell quantity in a variety of disorders of sex development suggests that fertility potential may be greater than previously thought.”
 - b. **Campo-Engelstein L, Chen D, Baratz AB, Johnson EK, Finlayson, C. The ethics of fertility preservation for pediatric patients with differences (disorders) of sex development. Journal of the Endocrine Society. 2017;1(6)638-645. doi: 10.1210/js.2017-00110** Future fertility potential should be considered in decision-making for individuals with DSD.
14. Early genital surgery for cosmetic purposes subjects children to unjustifiable risks of pediatric anesthetic neurotoxicity.
 - a. **Andropoulos DB, Greene MF. Anesthesia and developing brains — Implications of the FDA warning. New England Journal of Medicine. 2017;376:906-907.** In 2016, the FDA issued a warning that general anesthesia used in children less than 3 years old “may affect the development of children’s brains.” Texas Children’s Hospital limits procedures exposing young children to prolonged anesthesia to “serious or life-threatening congenital conditions for which there are no alternative treatments and for which treatment cannot be delayed.”

Multiple organizations oppose early genital surgeries/gender normalizing/assignment surgeries or support deferral until the patient can provide informed consent. These include:

World Health Organization

The United Nations Special Rapporteur on the Right to Health

The UN Secretary General's Special Representative on Violence Against Children

The UN High Commissioner for Human Rights

The United Nations Committee on the Rights of the Child

The United Nations Committee to End All Forms of Discrimination Against Women

The United Nations Committee Against Torture

The United Nations Committee on the Rights of Persons with Disabilities

United Nations agencies including UNICEF (children) and UNFPA (reproductive health)

North American Society for Pediatric and Adolescent Gynecology (NASPAG)

Pediatric Endocrine Society

Human Rights Watch

Physicians for Human Rights

The American Civil Liberties Union (ACLU)

German Ethics Council

Council of Europe Bioethics Commission

Parliamentary Assembly of the Council of Europe

DSD communities, including the AIS-DSD Support Group, and InterAct oppose early genital surgeries.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 4-I-18

Subject: CEJA Role in Implementing H-140.837, “Anti-Harassment Policy”

Presented by: James E. Sabin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution & Bylaws
(Todd M. Hertzberg, MD, Chair)

At the 2018 Annual Meeting the American Medical Association (AMA) House of Delegates (HOD) adopted with amendment the recommendations of Board of Trustees Report 20-A-18, “Anti-Harassment Policy.” The HOD amended the Board’s recommendations for a process to address allegations of harassment during meetings associated with the AMA to give the Council on Ethical and Judicial Affairs (CEJA) the authority and responsibility for taking disciplinary action (Policy H-140.837).

CEJA has discussed at length the recommendations of BOT Report 20-A-18 and believes that promoting safe engagement among physicians, students, staff, and other attendees during professional meetings affiliated with the AMA is an urgent organizational responsibility. However, while respecting the deliberations of the HOD, CEJA has concluded that the council is not in a position to carry out this new responsibility as defined in the recommendations as adopted.

CEJA concluded that the responsibility to adjudicate allegations of harassment is qualitatively different from its normal judicial function. In assessing individual physicians’ fitness for membership in the AMA, CEJA does not have direct, primary responsibility for taking punitive action. Rather, CEJA’s decisions rest on review of extensive case files compiled by state medical boards that have already taken disciplinary action and, with rare exceptions, an interview with the physician.

With respect to allegations of harassment, CEJA is deeply concerned that this new role will be much more analogous to that of a state medical board; it also foresees the need to engage with *both* parties before reaching a final determination. CEJA strongly believes that the task demands a different set of skills than its usual adjudications, and that therefore council members would need appropriate training (provided annually as new members join the council). CEJA is also uncertain that the range of [disciplinary options](#) available to it in its judicial function are appropriate with respect to allegations of harassment.

CEJA is further concerned that the council as a whole has neither the resources nor flexibility required to carry out this additional responsibility effectively. The council has a substantial ongoing workload in its normal judicial function, requiring at least one full day at each of its four in-person meetings every year. CEJA believes that allegations of harassment should be dealt with as close as possible to the time of the event by a body able to convene on an ad hoc basis. Moreover, the council has reason to anticipate a significant volume of cases, particularly in the current social climate.

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 Finally, CEJA is concerned as well that in reaching decisions that parties (and their supporters) see as
2 either excessive or inadequate may undermine confidence in the council, to the detriment of both its
3 judicial and policy work.

4
5 For these reasons, CEJA respectfully requests that H-140.837(3), "Disciplinary Action," be
6 reconsidered.

7
8 **RECOMMENDATION**

9
10 The Council on Ethical and Judicial Affairs recommends that the following be adopted and the
11 remainder of this report be filed:

- 12
13 1. That provision (3) of H-140.837, "Anti-Harassment Policy" be rescinded (Directive to Take
14 Action); and
15
16 2. That the process for implementing AMA's anti-harassment policy be referred to the Board of
17 Trustees for further study (Directive to Take Action)

Fiscal Note: Less than \$500

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 5-I-18

Subject: Physicians' Freedom of Speech
(Resolution 6-I-17)

Presented by: James E. Sabin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution & Bylaws
(Todd M. Hertzberg, MD, Chair)

At the 2017 Interim Meeting the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 6-I-17, "Physicians' Freedom of Speech," brought forward by the Minority Affairs Section. Resolution 6-I-17 asked the AMA to "encourage the Council on Ethical and Judicial Affairs (CEJA) to amend Ethical Opinion E-1.2.10, 'Political Action by Physicians'," by addition to read as follows:

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

Physicians who participate in advocacy activities should:

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

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

(c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients.

(d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

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Furthermore, physicians:

(e) Should indicate they are expressing their personal opinions, which are guaranteed under the First Amendment of the U.S. Constitution, and should refrain from implying or stating that they are speaking on behalf of their employers;

(f) Should be allowed to express their personal opinions publicly without being subjected to disciplinary actions or termination.

Testimony supported the spirit of this resolution; however, concerns were expressed regarding the appropriate wording of the additional clauses offered by the author.

AMA ETHICS POLICY

As Opinion E-1.2.10 indicates, the AMA *Code of Medical Ethics* recognizes that physicians have a right to advocate for change in law and policy, and indeed have a responsibility to do so when existing law or policy is contrary to patients' interests, a responsibility codified in Principle III of the [AMA Principles of Medical Ethics](#), which states, "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient."

The *Code* also recognizes that we have the right to communicate our personal political views to patients and patients' families, within the constraints set out in Opinion [E-2.3.4](#), "Political Communication."

Similarly, the *Code* recognizes our right to due process in disciplinary actions and decisions regarding credentialing and privileging in Opinions [E-9.4.1](#), "Peer Review and Due Process"; [E-9.4.3](#), "Discipline and Medicine"; and [E-9.4.4](#), "Physicians with Disruptive Behavior," all of which prohibit unwarranted or malicious action against physicians.

In Opinion [E-2.3.2](#), "Professionalism in the Use of Social Media," the *Code* recognizes that "participating in social networking and other similar opportunities can support physicians' personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunities to widely disseminate public health messages and other health communication." However, [E-2.3.2](#) also cautions physicians to be aware that "actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students) and can undermine public trust in medicine."

Although the *Code* does not, and indeed cannot, dictate the terms of physician employment as such, several additional opinions do address relationships between physicians and the institutions with which they are affiliated, as employees or otherwise. Thus Opinion [E-8.7](#), "Routine, Universal Immunization of Physicians," provides that physicians who decline to be immunized must accept decisions of medical staff leadership or other authority to adjust practice activities. [E-11.2.3](#), "Contracts to Deliver Health Care Services," calls on us to carefully review the terms of contracts and "negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical standards," while [E-11.2.3.1](#), "Restrictive Covenants," holds that we should not enter into agreements that "unreasonably restrict" our right "to practice for a specified time or in a specific geographic area on termination of a contractual relationship."

ACTIONS AGAINST PHYSICIANS' LICENSES OR EMPLOYMENT

The Federation of State Medical Boards does not systematically track violations of online professionalism, but a 2012 survey indicated that medical and osteopathic boards have acted against physicians for violating patient privacy or professional boundaries, and other unprofessional or offensive conduct online [Greyson et al 2012]. Researchers found at the time that the total number of actions was small but observed that “this is likely to change as the use of social media continues to grow.”

Information about termination or other actions taken against physicians by their employers is limited primarily to media accounts of individual cases [Advisory Board 2011, Canosa 2016, Anderson 2018]. Publicly reported incidents involve both patient-related issues, such as violation of confidentiality, and offensive personal conduct, such as racist speech [Canosa, Anderson].

FREEDOM OF SPEECH

Although constitutional protection for “freedom of speech” is often invoked as an argument against disciplinary action by employers, it is important to note that this concept does not apply to private places of employment. The First Amendment “limits only the government’s ability to suppress speech” [Cox 2015].

Private employers generally have the power to terminate an employee because of the employee’s speech. For example, Thomas Jefferson University Hospital noted in a statement regarding the hospital’s decision to dismiss a nurse for a racially charged post,

An employee’s decision to post inflammatory comments on social media is an unfortunate choice and one that is not tolerated at Jefferson Whether we choose to acknowledge it or not, we must recognize that what we say on social media can directly affect how people perceive Jefferson — particularly when those comments put into question Jefferson’s commitment to the care of our patients, treatment of our fellow colleagues and education of our students [Craig].

Protections for an employee regarding their speech in the private workplace, are possible, but come from outside of the sphere of constitutional law. Instead such protections may be found in contract and employment law. For example, common law analysis of the standard “employment-at-will” doctrine (where an employer can terminate an employee at any time for any reason), provide for exceptions, such that employers may not “contravene public policy” or that employers must act in accordance to an “implied convent of good faith and fair dealing” [McGinley 2012]. Or an employer may simply have an employment policy or agreement that outlines acceptable speech, providing an employee with contract remedies. These possible speech protections are sourced from contract and employment law, illustrating that “freedom of speech” in the private workplace is an employment law issue, not a constitutional rights issue.

CONCLUSION

In CEJA’s view, the situation of physicians who express personal views on political and social issues online is importantly like that of physicians who participate professionally in the media. We should recognize that even when we speak personally, we are likely to be viewed by the public through the lens of our professional status and our relationships with health care institutions and should not conduct ourselves in ways that are likely to undermine trust in our profession or health care institutions. As Opinion [E-8.12](#), “Ethical Physician Conduct in the

1 Media,” observes, physicians in the public sphere “should be aware of their ethical obligations to
2 patients, the public, and the medical profession; and that their conduct can affect their medical
3 colleagues, other health care professionals, as well as institutions with which they are affiliated.”
4

5 CEJA concludes, thus, that in its present form, the *Code of Medical Ethics* provides appropriate
6 guidance with respect to physicians’ rights to express ourselves on matters of social and political
7 importance and underscores our right to due process when our conduct is subjected to disciplinary
8 review.
9

10 RECOMMENDATION

11
12 For the foregoing reasons, the Council on Ethical and Judicial Affairs recommends that
13 Resolution 6-I-17, “Physicians’ Freedom of Speech,” not be adopted and the remainder of this
14 report be filed.

Fiscal Note: Less than \$500

REFERENCES

1. Greyson SR, Chretien KC, Kind T, Young A, Gross CP. Physician violations of online professionalism and disciplinary action: a national survey of state medical boards. *JAMA* 2012;307:1141–1142.
2. Advisory Board You're fired! RI physician reprimanded for Facebook post. 2011;April 22. Available at <https://www.advisory.com/daily-briefing/2011/04/22/youre-fired-ri-physician-reprimanded-for-facebook-post>. Accessed October 1, 2018.
3. Canosa S. the danger of social media for healthcare professionals. *HealtheCareers* 2016;October 3. Available at <https://www.healthcareers.com/article/career/social-media-healthcare-professionals>. Accessed October 1, 2018.
4. Anderson, C. Stephon Clark “deserved it,” nurse wrote on Facebook. Now she’s no longer working for Kaiser. *Sacramento Bee* 2018;April 1. Available at <https://www.sacbee.com/news/local/health-and-medicine/article207364464.html>. Accessed September 26, 2018.
5. Cox J. A Chill Around the water cooler: first amendment in the workplace. *American Bar Association* 2015; Winter. Available at https://www.americanbar.org/publications/insights_on_law_and_society/15/winter-2015/chill-around-the-water-cooler.html. Accessed September 27, 2018.
6. Craig D. Employee at Philly hospital loses job over racially charged Facebook post. *PhillyVoice* 2016;July 14. Available at <https://www.phillyvoice.com/employee-philly-hospital-fired-over-racially-charged-facebook-post/>. Accessed October 1, 2018.
7. McGinley AC, McGinley-Stempel RP. Beyond the water cooler: speech and media in the workplace in an era of social media. *Hofstra Lab. & Emp. L. J.* 2012;30:75–119.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(I-18)

Introduced by: Wisconsin

Subject: Support of a National Registry for Advance Directives

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Todd M. Hertzberg, MD, Chair)

1 Whereas, Advanced Care Planning (ACP) may include but is not limited to appointing a
2 Healthcare Power of Attorney, completing a living will, and/or completing an advance directive;¹
3 and
4

5 Whereas, ACP has the central goal of ensuring that a patient's wishes and preferences in
6 relation to his or her healthcare decisions are respected;² and
7

8 Whereas, ACP improves respecting end-of-life wishes and patient and family satisfaction while
9 reducing family member anxiety and stress;³⁻⁴ and
10

11 Whereas, Studies suggest that ACP is cost-effective in end-of-life care;⁵⁻⁶ and
12

13 Whereas, ACP documentation varies by state and region and is often difficult to locate;⁷⁻¹⁰ and
14

15 Whereas, There is no central database of ACP documentation that is confidential, secure, free
16 of charge, and readily accessible for healthcare providers; therefore be it
17

18 RESOLVED, That our American Medical Association advocate for the establishment and
19 maintenance of a national, no-charge, confidential and secure method for the storage and
20 retrieval of advance directive documents by authorized agents. (New HOD Policy)

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

Received: 09/25/18

RELEVANT AMA POLICY

Encouraging the Use of Advance Directives and Health Care Powers of Attorney H-140.845

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 9, I-15; Reaffirmed: Res. 517, A-16; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17

References:

1. Junkerman, C., Derse, A. and Schiedermayer, D. (2008). *Practical ethics for students, interns, and residents*. Hagerstown, Md.: University Pub. Group.
2. Deciding for Others: Limitations of Advance Directives, Substituted Judgment, and Best Interest. (2009). *Virtual Mentor*, 11(8), pp.571-581.
3. Detering, K., Hancock, A., Reade, M. and Silvester, W. (2010). The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. *BMJ*, 340(mar23 1), pp.c1345-c1345.
4. Brinkman-Stoppelenburg, A., Rietjens, J. and van der Heide, A. (2014). The effects of advance care planning on end-of-life care: A systematic review. *Palliative Medicine*, 28(8), pp.1000-1025.
5. Nguyen, K. H., Sellars, M., Agar, M., Kurrle, S., Kelly, A., & Comans, T. (2017). An economic model of advance care planning in Australia: a cost-effective way to respect patient choice. *BMC health services research*, 17(1), 797.
6. Klingler, C., in der Schmitzen, J., & Marckmann, G. (2016). Does facilitated Advance Care Planning reduce the costs of care near the end of life? Systematic review and ethical considerations. *Palliative Medicine*, 30(5), 423–433. <http://doi.org/10.1177/0269216315601346>
7. ASPE. (2018). *Advance Directives and Advance Care Planning: Legal and Policy Issues*. [online] Available at: <https://aspe.hhs.gov/basic-report/advance-directives-and-advance-care-planning-legal-and-policy-issues#POLST> [Accessed 18 Jan. 2018].
8. Wilson, C., Newman, J., Tapper, S., Lai, S., Cheng, P., Wu, F. and Tai-Seale, M. (2013). Multiple Locations of Advance Care Planning Documentation in an Electronic Health Record: Are They Easy to Find?. *Journal of Palliative Medicine*, 16(9), pp.1089-1094.
9. Platts-Mills, T., Richmond, N., LeFebvre, E., Mangipudi, S., Hollowell, A., Travers, D., Biese, K., Hanson, L. and Volandes, A. (2017). Availability of Advance Care Planning Documentation for Older Emergency Department Patients: A Cross-Sectional Study. *Journal of Palliative Medicine*, 20(1), pp.74-78.
10. Walker, E., McMahan, R., Barnes, D., Katen, M., Lamas, D. and Sudore, R. (2017). Advance Care Planning Documentation Practices and Accessibility in the Electronic Health Record: Implications for Patient Safety. *Journal of Pain and Symptom Management*.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(I-18)

Introduced by: GLMA: Health Professionals Advancing LGBTQ Equality

Subject: Protecting the Integrity of Public Health Data Collection

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Todd M. Hertzberg, MD, Chair)

1 Whereas, Our American Medical Association is dedicated to improving the nation's health; and

2
3 Whereas, The National Institutes of Health (NIH) has underscored the need to better
4 understand the health of sexual and gender minorities and the 2011 Institute of Medicine report
5 on the Health of Lesbian, Gay, Bisexual, and Transgender People and a follow-up report in
6 2013 both highlighted the need for inclusion of sexual and gender identity data collection in
7 federal and state surveys, surveillance systems, and health registries¹⁻²; and

8
9 Whereas, Healthy People 2020 Guidelines highlight the importance of sexual orientation and
10 gender identity data collection in national surveys³; and

11
12 Whereas, There have been several attempts to remove sexual orientation and gender identity
13 data from national surveys and surveillance systems, including but not limited to the National
14 Survey of Older American Act⁵ and National Crime Victimization Survey⁶; and

15
16 Whereas, This is part of an alarming trend within the federal government aimed at limiting
17 knowledge about sexual and gender minority (i.e. lesbian, gay, bisexual, transgender, queer)
18 people, despite the fact that these data are vital to policy making and designing evidence-based
19 interventions to improve health and well-being; and

20
21 Whereas, The collection of sexual orientation and gender identity data allows researchers,
22 clinicians, and public health professionals to address health disparities and ensure individuals
23 can lead long, healthy lives and appropriate data collection allows for the reduction in disease
24 transmission and progression, increases in mental and physical well-being, reductions in health
25 care costs, and improved quality of life; and

26
27 Whereas, To eliminate health disparities, there must be widespread collection of sexual
28 orientation and gender identity data using standard, reliable questions⁷; therefore be it

29
30 RESOLVED, That our American Medical Association advocate for the inclusion of demographic
31 data inclusive of sexual orientation and gender identity in national and state surveys,
32 surveillance systems, and health registries; including but not limited to the Current Population
33 Survey, United States Census, National Survey of Older Americans Act Participants, all-payer
34 claims databases (New HOD Policy); and be it further

35
36 RESOLVED, That our AMA advocate against the removal of demographic data inclusive of
37 sexual orientation and gender identity in national and state surveys, surveillance systems, and
38 health registries without plans for updating measures of such demographic data. (New HOD
39 Policy)

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

Received: 10/11/18

References:

1. Institute of Medicine (IOM) (2011). The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. Washington (DC): National Academies Press (US). Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22013611>. Accessed December 10, 2017.
2. National Institutes of Health Sexual and Gender Minority Research Coordinating Committee. (2015) *NIH FY 2016-2020 Strategic Plan to Advance Research on the Health and Well-being of Sexual and Gender Minorities* Washington, DC: NIH.
3. Office of Disease Prevention and Health Promotion. Healthy People 2020 Topics & Objectives: Lesbian, Gay, Bisexual, and Transgender Health. Available at <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health>. Accessed May 21, 2018
4. Singh S, Durso LE, Tax A. "The Trump Administration Is Rolling Back Data Collection on LGBT Older Adults." Center for American Progress. Available at <https://www.americanprogress.org/issues/lgbt/news/2017/03/20/428623/trump-administration-rolling-back-data-collection-lgbt-older-adults/>. Accessed May 22, 2018
5. Benner K. "Federal Prisons Roll Back Rules Protecting Transgender People." New York Times. May 11, 2018. Available at <https://www.nytimes.com/2018/05/11/us/politics/justice-department-transgender-inmates-crime-victims.html>. Accessed May 22, 2018
6. Smedley B, Stith AY, Nelson AR. (2002) *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington: National Academies Press.

RELEVANT AMA POLICY

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; and (2) will advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health.

Citation: Res. 212, I-16; Reaffirmed in lieu of: Res. 008, A-17

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals 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; (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.

Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18

Goal of Health Care Data Collection H-406.999

The AMA (1) continues to advocate that health care data collected by government and third party payers be used for education of both consumers and providers; and (2) believes that government, third party payers and self-insured companies should make physician-specific utilization information available to medical societies.

Citation: BOT Rep. W, A-92; Reaffirmed: Res. 719, A-93; BOT Rep. Y, I-85; Reaffirmed CLRPD Rep. 2, I-95; CMS Rep. 10, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(I-18)

Introduced by: Indiana

Subject: Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Todd M. Hertzberg, MD, Chair)

1 Whereas, Federal government immigration officials recently elected to separate children from
2 their parent or parents and to place these children in foster care situations or other public
3 facilities. The children were as young as 3 years of age. In some cases, this occurred with little
4 or no forewarning, so that the parents were not able to prepare their children for the separation.
5 Some children became quite stressed and agitated. In some cases, the children were moved
6 thousands of miles for the foster care. Previous administrations have had a policy allowing
7 unaccompanied minors access to the U.S. This policy produced concerns about the possibility
8 of entry into gangs and the risk of physical and mental trauma in the absence of a supervising
9 adult; and

10
11 Whereas, A single major childhood emotional trauma can predispose a person to chronic
12 psychiatric disease as an adult. Many of these border-crossing children have experienced
13 multiple traumas already on their travels to the U.S.; and

14
15 Whereas, Some of the minor immigrant children were given psychotropic drugs without parental
16 permission or court order. These children protested injection verbally. They were held by guards
17 at detention centers and psychotropic drugs were given; therefore be it

18
19 RESOLVED, That our American Medical Association officially object to policies separating
20 undocumented immigrant parents and/or guardians from children, as well as allowing
21 unaccompanied undocumented minors access to the U.S. (New HOD Policy); and be it further
22

23 RESOLVED, That our AMA condemn the practice of administering psychotropic drugs to
24 immigrant children without parental or guardian consent or court order except in the case of
25 imminent danger to self or others (New HOD Policy); and be it further
26

27 RESOLVED, That our AMA support a position whereby federal immigration officials would
28 become more aware of the emotional decompensation in this immigrant population, with the
29 establishment of policies designed to decrease stress and emotional trauma. (New HOD Policy)

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

Received: 10/09/18

RELEVANT AMA POLICY

<https://policysearch.ama-assn.org/policyfinder/search/undocumented%20children/relevant/1/>

Reference Committee B

BOT Report(s)

- 04 Increased Use of Body-Worn Cameras by Law Enforcement Officers
- 05 Exclusive State Control of Methadone Clinics
- 07 Advocacy for Seamless Interface Between Physicians Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs
- 08 340B Drug Discount Program
- 11 Violence Prevention

Resolution(s)

- 201 Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application
- 202 Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings
- 203 Support for the Development and Distribution of HIPAA-Compliant Communication Technologies
- 204 Restriction on IMG Moonlighting
- 205 Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)
- 206 Repealing Potential Penalties Associated with MIPS
- 207 Defense of Affirmative Action
- 208 Increasing Access to Broadband Internet to Reduce Health Disparities
- 209 Sexual Assault Education and Prevention in Public Schools
- 210 Forced Organ Harvesting for Transplantation
- 211 Eliminating Barriers to Automated External Defibrillator Use
- 212 Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings
- 213 Increasing Firearm Safety to Prevent Accidental Child Deaths
- 214 A Public Health Case for Firearm Regulation
- 215* Extending the Medical Home to Meet Families Wherever They Go
- 216* Medicare Part B Competitive Acquisition Program (CAP)
- 217* Opposition to Medicare Part B to Part D Changes
- 218* Alternatives to Tort for Medical Liability
- 219* Promotion and Education of Breastfeeding
- 220* Supporting Mental Health Training Programs for Corrections Officers and Crisis Intervention Teams for Law Enforcement
- 221* Regulatory Relief from Burdensome CMS "HPI" EHR Requirements
- 222* Patient Privacy Invasion by the Submission of Fully Identified Quality Measure Data to CMS
- 223* Permanent Reauthorization of the State Children's Health Insurance Program
- 224* Fairness in the Centers for Medicare and Medicaid Services Authorized Quality Improvement Organization's (QIO) Medical Care Review Process
- 225* Surprise Out of Network Bills
- 226* Support for Interoperability of Clinical Data
- 227* CMS Proposal to Consolidate Evaluation and Management Services

* contained in the Handbook Addendum

REPORT OF THE BOARD OF TRUSTEES

B of T Report 04-I-18

Subject: Increased Use of Body-Worn Cameras by Law Enforcement Officers
(Resolution 208-I-17)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 INTRODUCTION

2
3 At the 2017 Interim Meeting, the House of Delegates referred Resolution 208-I-17, “Increased Use
4 of Body-Worn Cameras by Law Enforcement Officers,” introduced by the Medical Student
5 Section, which asked:

6
7 That our American Medical Association advocate for legislative, administrative, or regulatory
8 measures to expand funding for (1) the purchase of body-worn cameras and (2) training and
9 technical assistance required to implement body-worn camera programs.

10
11 The reference committee heard testimony largely in support of referral. Testimony emphasized the
12 use of body-worn cameras by law enforcement officers was a matter of public health and directly
13 related to existing American Medical Association (AMA) policy concerning the health of
14 minorities. Others expressed concern that the issues being raised were outside of the expertise and
15 scope of our AMA. The reference committee recommended referral in order to address all concerns
16 raised by Resolution 218. This Board report provides background, discussion of body-worn
17 cameras by law enforcement officers, and a recommendation.

18 19 BACKGROUND

20
21 Following a number of high-profile incidents involving deadly force used against minorities, law
22 enforcement agencies have increasingly adopted body-worn cameras for their officers. Often
23 affixed to the torso, body-worn cameras are small, wearable audio, video or photographic recording
24 systems that record events in which law enforcement officers are involved. The recordings can be
25 used to demonstrate transparency to the community, to document events and to deter inappropriate,
26 illegal or unethical behavior by both the wearer of the camera and the public.

27
28 To date, 34 states and the District of Columbia have enacted laws governing the use of body-worn
29 cameras by law enforcement, though not all law enforcement departments utilize cameras in the
30 same manner.¹ For example, some permit officers to turn off the devices under certain
31 circumstances; others do not. In addition, a 2016 survey of large police departments nationwide
32 found that 95 percent intended to implement or had already implemented a body camera program.
33 According to the survey, 18 percent had fully operational programs.²

34
35 The cost to law enforcement entities to implement and maintain a body camera program can be
36 costly and is an ongoing expense. Implementing a program requires an initial capital outlay to

1 purchase the technology and ancillary equipment; law enforcement agencies must account for
 2 continuing operational costs, such as training on use, data storage, software and staff and
 3 operational costs required for reviewing the recordings, redacting as necessary, and providing
 4 recordings to courts and the public as appropriate. In Washington, DC, for example, the city spent
 5 over \$1 million outfitting 2,800 officers and expects operating costs to top \$2 million per year.³
 6

7 In 2015, the U.S. Department of Justice (DOJ) Bureau of Justice Assistance (BJA) awarded
 8 \$22.5 million in grant assistance to state and local law enforcement departments as part of the
 9 Body-Worn Camera Pilot Implementation Program. The Consolidated Appropriations Act, 2018
 10 appropriated \$22.5 million for a competitive matching grant program for purchases of body-worn
 11 cameras for state, local and tribal law enforcement. The BJA expects to make up to 28 awards for a
 12 three-year period, to begin on October 1, 2018. State and local funding is also available for
 13 body-worn cameras.
 14

15 DISCUSSION

16
 17 Predicated on whether the AMA ought to support funding of body camera programs is the question
 18 of whether the AMA ought to support the expanded use of body cameras and whether the devices
 19 achieve their intended outcomes.
 20

21 *Policing Activity*

22
 23 The underlying theory in support of body-worn cameras is that both officers and members of the
 24 community will change their behaviors for the better if their actions are being recorded. Indeed, a
 25 large body of research suggests that people act differently when they believe they are being
 26 watched. In the context of law enforcement, body-worn cameras are expected to increase self-
 27 awareness and thus deter unprofessional, inappropriate and illegal behavior by officers and
 28 civilians alike. As law enforcement officers are more likely to use force against minority
 29 community members, many hope body-worn cameras will improve policing behavior toward
 30 minorities, using force only when warranted and de-escalation tactics have failed.^{4,5} In cases where
 31 law enforcement officers do use force, body-worn cameras offer contemporaneous evidence of the
 32 officers' actions so that improper behavior can be disciplined. Evidence about the impact of
 33 cameras on policing activity generally, though not universally, supports this theory.
 34

35 An early study conducted in the Rialto, California police department found use-of-force incidents
 36 declined 58.3 percent over a three-year period after a body camera program was implemented.⁶
 37 Importantly, researchers later found that use of force rates were higher in the same Rialto,
 38 California police force despite the presence of a camera when officers were allowed discretion to
 39 turn off cameras.⁷ Another randomized controlled trial conducted between 2014 and 2015 in the
 40 Las Vegas Metropolitan Police Department found that officers wearing body cameras were
 41 12.5 percent less likely to be involved in a use of force incident.⁸ Similar results were found in
 42 Orlando, Florida.⁹ In contrast, the largest randomized controlled study to date, conducted in 2015
 43 with the Metropolitan Police Department of the District of Columbia, found no statistically
 44 significant difference in the rates of police use of force.¹⁰
 45

46 Research has found mixed results about other forms of police activity. In the study conducted in
 47 Las Vegas, body camera use was not associated with a change in the number of police-community
 48 interactions, but body cameras were associated with a 6.8 percent increase in the number of
 49 citations issued and a 5.2 percent increase in the number of events that resulted in an arrest. A 2015
 50 study conducted in Mesa, Arizona found officers wearing a camera were less likely to perform
 51 stop-and-frisks and make arrests, but were more likely to give citations and initiate encounters.¹¹ In

Phoenix, Arizona use of body-worn cameras were associated with a 17 percent increase in arrests.¹² However, other studies have found body-worn cameras are associated with slightly lower incidents of arrest.¹³

Community Relations

Changing policing behaviors is not the only way body-worn cameras could provide benefits. Many communities and law enforcement agencies see body cameras as a valuable way to improve policing transparency and community relations. Indeed, in 2015 when DOJ grants were announced, then-US Attorney General Loretta Lynch stated that body-worn cameras hold “tremendous promise for enhancing transparency, promoting accountability, and advancing public safety for law enforcement officers and the communities they serve.”¹⁴ Body cameras are lauded as a way for the public to better understand what transpires between law enforcement officers and civilians. Officers may also view body cameras positively, as recordings demonstrate to the community the difficult and dangerous job required of them.

Few studies have taken a comprehensive look at community attitudes toward police after the introduction of body-worn cameras.¹⁵ One such study conducted by the Urban Institute found that body-worn cameras do improve community members’ satisfaction with police encounters.¹³ Another study found that individuals viewed officers as having greater legitimacy, professionalism and satisfaction, but did not find significant differences between citizens’ perceptions of officers depending on whether the officer was wearing a camera.¹⁶

The evidence is clearer, however, that body-worn cameras are associated with decreased rates of complaints filed against law enforcement officers. For example, one early study found complaints against officers dropped 88 percent following implementation of a body cameras program.⁶ In Rialto, California, citizen complaints declined by 60 percent. In the Las Vegas Metropolitan Police, officers wearing body cameras were 14 percent less likely to be the subject of a citizen complaint.⁸ In Phoenix, complaints against officers who wore the cameras declined by 23 percent, compared to a 10.6 percent increase among comparison officers.¹² In contrast, research in the District of Columbia found no statistically significant difference in the rates of civilian complaints.

The available evidence does not identify the underlying behavioral changes responsible for the decline in complaint rates, however. It may be that body-worn cameras have the intended effect of changing officer behavior for the better, thus reducing circumstances that warrant citizen complaints. It may be that cameras have a “civilizing” effect on members of the public as well. Some evidence also suggests that frivolous complaints are less likely to be filed when recordings are available.¹⁵

It is important to note, however, that use of body cameras will not automatically foster greater trust between law enforcement and members of the community and should not be viewed, as one evaluation noted, as a “plug-and-play” solution.¹⁰ Notably, the Urban Institute found body-worn cameras improved community satisfaction to a lesser extent than did procedurally just practices, defined in that study as behaving fairly and acting with empathy.¹³

Privacy Considerations

Though the use of body cameras promises greater transparency of law enforcement behavior and actions, they also present new problems, namely intrusion into the privacy of victims, witnesses and bystanders. For instance, law enforcement officers frequently enter individuals’ homes and in-home recordings would become part of the public record. Similarly, interactions and conversations

with victims and witnesses could make those individuals uncomfortable or put those individuals in danger. Heavily policed communities – often minority communities – will be more heavily recorded.

These privacy concerns could be addressed with policies to limit recording during such encounters and by limiting the circumstances under which recordings are made available to the public. The American Civil Liberties Union (ACLU) recommends use of body cameras with significant privacy protections. Officer privacy may also be a concern. Some law enforcement unions have opposed body-worn cameras, arguing that adoption of the technology must be negotiated as part of the collective bargaining agreement.

This report acknowledges the significant privacy concerns raised by the ubiquitous use of body-worn cameras, but notes that questions about when cameras need to be turned on and off, how long to keep footage, when recordings will be made publicly available and other policy details are beyond the expertise of the AMA.

Nexus with the AMA's Mission

The AMA does not have policy specifically addressing the use of body-worn cameras among law enforcement. During the debate over Resolution 208 during the 2017 Interim Meeting, the reference committee heard testimony questioning whether this topic is within the scope of the AMA's expertise. This concern is reasonable, as AMA has not historically delved into issues of policing and significant resources would be required to bring the AMA into the public policy debates surrounding community policing efforts. Further, while there are dozens of organizations (the Police Executive Research Forum, Leadership Conference on Civil and Human Rights, ACLU, etc.) that are actively engaged on this issue, it does not appear that any other major medical associations have emerged as significant stakeholders.

Nevertheless, there is a connection between health and police activity, particularly in terms of minority fatality rates. Research has demonstrated that minority communities are disproportionately subject to police force. Specifically, according to an analysis of FBI statistics, African-Americans account for 31 percent of police-involved shootings, but comprise 13 percent of the U.S. population.⁴ African-American males are particularly at risk. According to another analysis, African-American males are three times more likely to be killed by police than non-Hispanic white males.⁵

Research has also shown a correlation between policing and other health outcomes. In particular, a recent study found that police killings of unarmed African-Americans were associated with 1.7 days of poor mental health annually among African-Americans. The findings were seen regardless of whether the individual affected had a personal relationship with the victim or whether the incident was experienced vicariously. In addition, the numbers of police stops, coupled with the level of invasiveness during police encounters, is associated with increased levels of stress and anxiety.^{17,18} African-American men report more anxiety and post-traumatic stress disorder and more morbidity from these psychiatric conditions than Caucasian men.⁵ In addition, research of data from the New York Police Department revealed that residents in neighborhoods with higher rates of stop-and-frisks were more likely to be in poor health, measured in terms of high blood pressure, diabetes, asthma and self-rated health.¹⁸ Research on the correlation between health and policing, however, remains sparse and warrants further research.

1 RELEVANT AMA POLICIES

2
3 Existing AMA policy does not address the use or funding of body-worn cameras. However, AMA
4 policy does state that physical or verbal violence between law enforcement officers and the public,
5 particularly within ethnic and racial minority communities, is a social determinant of health and
6 supports research into the public health effects of violent interactions. (H-515.955) In addition,
7 Policy H-350.971 “AMA Initiatives Regarding Minorities” instructs the AMA to establish a
8 mechanism to facilitate the development and implementation of a comprehensive, long-range,
9 coordinated strategy to address issues and concerns affecting minorities, including minority health.

10
11 New policy adopted during the 2018 Annual Meeting encourages states to require the reporting of
12 legal intervention deaths and law enforcement officer homicides to public health agencies. New
13 policy also encourage appropriate stakeholders, including law enforcement and public health
14 communities, to define “serious injuries” for the purpose of systematically collecting data on law
15 enforcement-related non-fatal injuries among civilians and officers.

16
17 Additionally, Policy H-145.977 “Use of Conducted Electrical Devices by Law Enforcement
18 Agencies” cautions against excessive use of conducted electrical devices (often called Tasers) and
19 recommends that law enforcement departments and agencies should have in place specific
20 guidelines, rigorous training and an accountability system for the use of conducted electrical
21 devices. AMA policy recommends research into the health impacts of conducted electrical device
22 use and development of a standardized protocol developed with the input of the medical
23 community for the evaluation, management and post-exposure monitoring of subjects exposed to
24 conducted electrical devices.

25
26 RECOMMENDATION

27
28 The Board recommends that the following be adopted in lieu of Resolution 208-I-17, and that the
29 remainder of the report be filed.

30
31 That our American Medical Association work with interested state and national medical
32 specialty societies to support state legislation and/or regulation that would encourage the use of
33 body-worn camera programs for law enforcement officers and fund the purchase of body-worn
34 cameras, training for officers and technical assistance for law enforcement agencies.

Fiscal Note: Less than \$5,000

REFERENCES

1. National Conference of State Legislatures. Body-Worn Camera Laws Database. Available at <http://www.ncsl.org/research/civil-and-criminal-justice/body-worn-cameras-interactive-graphic.aspx>. Accessed June 27, 2018.
2. Major Cities Chiefs Association and Major County Sheriffs Association. Technology Needs – Body Worn Cameras. Available at <https://assets.bwbx.io/documents/users/iqjWHBFdfxIU/rvnT.EAJQwK4/v0>. Accessed June 27, 2018.
3. Austermuhle M. Almost every D.C. cop is getting a body camera. Here's what you need to know. Available at https://wamu.org/story/15/12/15/just_about_every_dc_cop_will_soon_have_a_body_camera_heres_what_you_need_to_know/. Accessed June 27, 2018.
4. Lopez G. Police shootings and brutality in the US: 9 things you should know. Available at <https://www.vox.com/cards/police-brutality-shootings-us/us-police-racism>. Accessed June 27, 2018.
5. Brown CA, Powell W, Corbie-Smith G, Ritchie O. Evidence Brief: Health Equity Implications of Police Violence. Available at https://cher.unc.edu/evidence-brief-health-equity-implications-police-violence/#_ednref9. Accessed June 27, 2018.
6. Ariel B, Farrar W, Sutherland A. The effect of police body-worn cameras on use of force and citizens' complaints against the police: a randomized controlled trial, *Journal of Quantitative Criminology*. 2015;31(3):509-535.
7. Ariel B, Sutherland A, Henstock D. Report: increases in police use of force in the presence of body-worn cameras are driven by officer discretion: a protocol-based subgroup analysis of ten randomized experiments. *Journal of Experimental Criminology*. 2016;12(3):453-463.
8. Braga A, Coldren JR, Sousa W, et al.. The benefits of body-worn cameras: new findings from a randomized controlled trial at the Las Vegas metropolitan police department. Available at <https://www.ncjrs.gov/pdffiles1/nij/grants/251416.pdf>. Accessed June 27, 2018.
9. Jennings WG, Lynch MD, Fridell LA. Evaluating the impact of police officer body-worn cameras (BWCs) on response-to-resistance and serious external complaints: Evidence from the Orlando police department (OPD) experience utilizing a randomized controlled experiment. *Journal of Criminal Justice*. 2015;43:480-486.
10. Yokum D, Ravishanakar A, Coppock A. Evaluating the effects of police body worn cameras: a randomized controlled trial. Available at http://bwc.thelab.dc.gov/TheLabDC_MPD_BWC_Working_Paper_10.20.17.pdf.
11. Ready JR, Young JTN. The impact of on-officer video cameras on police-citizen contacts: findings from a controlled experiment in Mesa, AZ. *Journal of Experimental Criminology*. 2015;11(3):445-458.
12. Katz CM, Choate DE, Ready JR, et al. Evaluating the impact of officer worn body cameras in the Phoenix Police Department. Available at http://cvpcs.asu.edu/mwg-internal/de5fs23hu73ds/progress?id=Fth_wfMsfYuO3mr6DAyxfQYU58SYKtY9A6P-mB8sgqs. Accessed June 27, 2018.
13. McClure D, La Vigne N, Lynch M, et al. How body cameras affect community members' perceptions of police. Available at https://www.urban.org/sites/default/files/publication/91331/2001307-how-body-cameras-affect-community-members-perceptions-of-police_4.pdf. Accessed June 27, 2018.
14. Justice Department Announces \$20 million in funding to support body-worn camera pilot program. Available at <https://www.justice.gov/opa/pr/justice-department-announces-20-million-funding-support-body-worn-camera-pilot-program>. Accessed June 27, 2018.
15. White MD, Police officer body-worn cameras: assessing the evidence. Available at https://www.ojpdiagnosticcenter.org/sites/default/files/spotlight/download/Police_Officer_Body-Worn_Cameras.pdf. Accessed June 27, 2018.
16. Police Executive Research Forum. Citizen Perceptions of Body-Worn Cameras: A Randomized Controlled Trial. Available at <https://perf.memberclicks.net/assets/bodyworncameraperceptions.pdf>. Accessed June 27, 2018.
17. Geller A, Fagan J, Tyler T, Link BG. Aggressive Policing and the Mental Health of Young Urban Men. *American Journal of Public Health*. 2014;104(12):2321-2327.
18. Sewell AA, Jefferson KA, Lee H. Living under surveillance: Gender, psychological distress, and stop-question-and-frisk policing in New York City. *Social Sciences and Medicine*. 2016;159:1-13.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-I-18

Subject: Exclusive State Control of Methadone Clinics
(Resolution 211-I-17)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 INTRODUCTION

2
3 At the 2017 Interim Meeting, the House of Delegates referred Resolution 211-I-17, “Exclusive
4 State Control of Methadone Clinics,” introduced by the Indiana Delegation, which asked:

5
6 That our American Medical Association support complete state control of all aspects of
7 methadone clinic approval and operations; and, if deemed necessary, this control could be
8 granted on a state by state basis.
9

10 Reference committee testimony generally was mixed and noted that there is likely both a state and
11 federal role as it relates to methadone clinic approval and operations. Delegates encouraged further
12 study, including discussion about methadone clinic reporting to state prescription drug monitoring
13 programs (PDMP). This report reviews existing information, provides background and presents
14 recommendations.
15

16 DISCUSSION

17
18 Your Board strongly agrees with the authors of Resolution 211-I-17 that methadone clinics provide
19 a valuable service to patients with an opioid use disorder. Methadone maintenance therapy (MMT)
20 for the treatment of opioid use disorder has been used for more than 40 years to help patients,
21 having been approved in 1972 by the U.S. Food and Drug Administration (FDA) for treatment of
22 heroin addiction. The health and safety of methadone has been studied extensively and ample
23 evidence exists supporting its use to aid in mortality and crime reduction.¹
24

25 There are more than 1,600 certified opioid treatment programs (OTPs) offering methadone in the
26 U.S.² According to the Substance Abuse and Mental Health Services Administration (SAMHSA),
27 the number of persons receiving methadone increased by 34 percent from 2006 (258,752) to
28 2016 (345,443).³ With respect to opioid-related mortality, deaths attributed to methadone increased
29 rapidly from 1999 (784 deaths) to their peak in 2007 (5,518) and have steadily declined since with
30 3,373 methadone-related deaths in 2016, according to the Centers for Disease Control and
31 Prevention.⁴ It is beyond the scope of this report to detail whether the methadone use in these
32 deaths was for the treatment of pain, for opioid use disorder, related to illicit use or was a
33 complicating polypharmacy factor.
34

35 The FDA, U.S. Drug Enforcement Administration (DEA), U.S. Department of Health and Human
36 Services (HHS) and states each have a role to play in the oversight and administration of MMT.

FDA Regulatory Authority

Within the broad scope of FDA's regulatory authority is the review and approval of drugs, both brand name and generic. A general overview of the FDA process can be found online: <https://www.fda.gov/Drugs/DevelopmentApprovalProcess/default.htm#FDA>. With respect to methadone, the FDA approved a New Drug Application for methadone in 1947. There were intervening actions, but for the purposes of this report, the FDA issued regulations for methadone Investigational New Drugs in 1971; proposed new regulations in April 1972; and issued final regulations in December 1972.⁵

DEA Regulatory Authority

DEA authority with respect to methadone focuses on the medication's classification as a Schedule II controlled substance.⁶ Included within DEA's responsibilities is the "enforcement of the provisions of the Controlled Substances Act as they pertain to the manufacture, distribution, and dispensing of legally produced controlled substances." As a controlled substance, methadone falls within this scope.

HHS Regulatory Authority

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), a division within HHS, has broad regulatory authority concerning MMT and opioid treatment programs (OTP). This includes the authority to certify OTPs, which is defined as "a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication registered under 21 USC 823(g)(1)."⁷

Regulations concerning OTPs, where patients receive MMT (and other medications and treatments), provide guidance for numerous issues. These issues include accreditation of opioid treatment programs, certification and treatment standards for OTPs, procedures for review of suspension or proposed revocation of OTP certification, and of adverse action regarding withdrawal of approval of an accreditation body, and more.⁸

Specifically related to methadone, 42 CFR Part 8 provides that "methadone shall be administered or dispensed only in oral form and shall be formulated in such a way as to reduce its potential for parenteral abuse." It also provides that:

For each new patient enrolled in a program, the initial dose of methadone shall not exceed 30 milligrams and the total dose for the first day shall not exceed 40 milligrams, unless the program physician documents in the patient's record that 40 milligrams did not suppress opioid abstinence symptoms.

There also are requirements for frequency of patients receiving toxicology tests, treatment of pregnant patients, requirements for take-home doses of methadone, and more.⁹

State Authority

There are numerous areas where state regulatory authority and linkages with federal oversight exist regarding OTPs. One prominent area concerns who shall serve as the medical director of the OTP. Federal regulations require that the medical director must be "a physician licensed to practice medicine in the jurisdiction in which the [OTP] is located." State licensure is squarely within the exclusive control of state licensing boards. Federal regulations also require that there are adequate

1 staffing requirements, employment qualifications and other personnel-related issues. These are
2 within the control of the state. And while it is complicated and beyond the scope of this report,
3 states also have a certain amount of leeway in determining zoning requirements for where an OTP
4 would be located. Notably, your Board strongly supports OTPs being treated no differently than
5 any other medical clinic that may seek to provide care in a community.¹⁰

6
7 SAMHSA also has recognized the clear need for OTPs to work with leaders in the community to
8 ensure comprehensive support services. That is, to support/encourage collaborative, multiagency
9 surveillance efforts to obtain timely and comprehensive data to target interventions and inform
10 prevention and response efforts. This includes working with the community to help determine
11 where an OTP is most needed; how an OTP can be integrated into the community with the least
12 impact on neighborhoods and traffic, for example; how to help educate the community on the
13 benefits of treatment for opioid use disorder so as to reduce stigma; and other areas.¹¹

14
15 Another area of state control—which raises potential conflicts with federal law—concerns whether
16 OTPs should be required to report methadone dispensing information to the state PDMP. This issue
17 is extremely controversial. In fact, while this issue was raised by the resolution that gave rise to this
18 report, it also was raised in Resolution 507 from the 2018 Annual Meeting. Resolution 507-A-18
19 was referred for further study of a more extensive range of privacy and clinical issues relating to
20 PDMPs and OTPs. Given that your Board is currently deliberating on Resolution 507-A-18, and
21 the fact that SAMHSA has not specifically resolved the many issues associated with reporting OTP
22 information to state PDMPs,¹² your Board believes it would be prudent to delay further comment
23 here so as not to cause confusion with pending research and discussions. Your Board does note,
24 however, that our AMA continues to urge physicians to use PDMPs to help inform their clinical
25 decision making. There is nothing to prevent physicians and other health care professionals in an
26 OTP from checking the state PDMP to ensure a patient is not receiving prescriptions for controlled
27 substances from other providers. Whether an OTP should report to a PDMP, however, is a matter
28 of federal—not state—jurisdiction.

29
30 Additional areas where states can help complement the medical care provided at OTPs include
31 promotion of take-home naloxone (governed by state law); education that helps remove the stigma
32 associated with MMT and medication assisted treatment (MAT); working toward policies that
33 remove health insurance and pharmacy benefit management company barriers to receiving MMT
34 and MAT (e.g., prior authorization, network adequacy for mental health care); prompt and accurate
35 overdose reporting for surveillance efforts related to prevention, treatment, and response;
36 identification of linkages within the community to peer counseling and other support services, to
37 name a few.

38
39 Furthermore, to complement and assist OTPs with the federal requirement to help an OTP identify
40 and prevent patients from enrolling in multiple OTPs concurrently, states can develop
41 communications and other tools to help OTPs (and other health care providers) identify all OTPs
42 doing business in a state and in surrounding areas. Federal rules already require an OTP to take
43 reasonable measures to do this. It seems reasonable that this would be an area where the state,
44 working with health insurance companies and other payers, as well as with the medical community,
45 would be well-advised to develop such a mapping/informational tool. This would not only allow
46 OTPs to more easily communicate with each other, but it would help patients identify where OTPs
47 exist in the state.

48
49 In Indiana, for example, the federal OTP locator maintained by SAMHSA identifies 16 OTPs
50 operating in the state,¹³ but it does not allow for multiple states to be displayed simultaneously. The
51 SAMHSA locator also does not allow for multiple OTPs within the state to be displayed

simultaneously. While the AMA appreciates the technical and other challenges that may be present in maintaining and keeping a current list of OTPs, creating a more robust OTP locator tool may be an area where state-based expertise and multistate partnerships can tailor solutions so that patients and physicians would be able to more easily locate and communicate with OTPs.

AMA POLICY

Relevant AMA policy provides for strong support of access to methadone. This includes MMT used in combination with behavioral and social supports, as well as support for physicians and organized medicine to provide education and training regarding treatment of substance use disorders (Policy H-95.957, “Methadone Maintenance in Private Practice;” Policy D-120.985, “Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone”). AMA policy also calls for continued funding of OTPs operating in states (Policy D-95.999, “Reduction of Medical and Public Health Consequences of Drug Abuse: Update”); and for the AMA to “advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities” (Policy D-95.968, “Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder”). AMA policy also clearly supports MAT in correctional settings and in the community in conjunction with counseling (Policy H-430.987, “Opiate Replacement Therapy Programs in Correctional Facilities”).

AMA policy also calls for continued funding of OTPs operating in states (Policy D-95.999, “Reduction of Medical and Public Health Consequences of Drug Abuse: Update”); and for the AMA to “advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities” (Policy D-95.968, “Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder”).

AMA policy also provides, in part, that “local communities or regions should exercise the responsibility for assessing their needs with respect to the type, size, scope, and location of health care facilities. State governments should ensure that needs of the underserved are being met satisfactorily without wasteful duplication” (Policy H-205.992, “Supply and Distribution of Health Care Facilities”).

RECOMMENDATIONS

The Board recommends that the following recommendation be adopted in lieu of Resolution 211-I-17, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support the right of federally certified Opioid Treatment Programs (OTPs) to be located within residential, commercial and any other areas where there is a demonstrated medical need; (New HOD Policy)
2. That our AMA encourage state governments to collaborate with health insurance companies and other payers, state medical societies, national medical specialty societies, OTPs and other health care organizations to develop and disseminate resources that identify where OTP providers operate in a state and take part in surveillance efforts to obtain timely and comprehensive data to inform treatment opportunities; and (New HOD Policy)

- 1 3. That our AMA advocate for the federal agencies responsible for approving opioid treatment
- 2 programs to consider the views of state and local stakeholders when making decisions about
- 3 OTP locations and policies. (New HOD Policy)

Fiscal Note: \$2,500

REFERENCES

- ¹ See, for example, Kleber HD. Methadone Maintenance 4 Decades Later. JAMA. 2008;300(19):2303–2305. doi:10.1001/jama.2008.648. Available at <https://jamanetwork.com/journals/jama/fullarticle/182898>
- ² Opioid Treatment Program Directory. Substance Abuse and Mental Health Services Association. Available at <https://dpt2.samhsa.gov/treatment/directory.aspx>
- ³ U.S. Department Of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS): 2016 Data on Substance Abuse Treatment Facilities. Available at https://www.samhsa.gov/data/sites/default/files/2016_NSSATS.pdf
- ⁴ Opioid Overdose Deaths by Type of Opioid. Kaiser Family Foundation analysis of CDC data. Available at <https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-type-of-opioid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
- ⁵ For a thorough discussion of the history of methadone regulation, see Institute of Medicine (US) Committee on Federal Regulation of Methadone Treatment; Rettig RA, Yarmolinsky A, editors. Federal Regulation of Methadone Treatment. Washington (DC): National Academies Press (US); 1995. 5, Federal Regulation of Methadone Treatment. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK232105/>
- ⁶ Methadone drug summary. Drug Enforcement Administration Office of Diversion Control Drug & Chemical Evaluation Section. Available at https://www.deadiversion.usdoj.gov/drug_chem_info/methadone/methadone.pdf
- ⁷ 42 CFR Part 8, available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=3&SID=7282616ac574225f795d5849935efc45&ty=HTML&h=L&n=pt42.1.8&r=P&ART#se42.1.8_12
- ⁸ 42 CFR Part 8, available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=3&SID=7282616ac574225f795d5849935efc45&ty=HTML&h=L&n=pt42.1.8&r=P&ART#se42.1.8_12
- ⁹ 42 CFR Part 8.12
- ¹⁰ Examples of a zoning board denying the opening of a methadone clinic: “Philadelphia zoning board denies methadone clinic for northeast neighborhood,” <https://whyy.org/articles/zone14>/<https://whyy.org/articles/zone14/>; “Zoning Board denies Rochester methadone clinic’s appeal,” <http://www.fosters.com/news/20180314/zoning-board-denies-rochester-methadone-clinics-appeal>; “Proposed methadone clinic denied by Rockford committee,” <http://www.wifr.com/content/news/Proposed-Methadone-Clinic-Denied-by-Rockford-Committee-487830091.html>
- ¹¹ See Federal Guidelines for Opioid treatment Programs. Substance Abuse and Mental Health Services Administration. January 2015. Available at <https://store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf>
- ¹² Confidentiality of Substance Use Disorder Patient Records, U.S. Department of Health and Human Services. Final Rule. January 18, 2017. Available at <https://www.federalregister.gov/documents/2017/01/18/2017-00719/confidentiality-of-substance-use-disorder-patient-records>
- ¹³ Opioid Treatment Program Directory, SAMHSA, <https://dpt2.samhsa.gov/treatment/directory.aspx>

REPORT OF THE BOARD OF TRUSTEES

B of T Report 7-I-18

Subject: Advocacy for Seamless Interface Between Physicians Electronic Health Records (EHRs), Pharmacies and Prescription Drug Monitoring Programs (PDMPs) (Resolution 212-A-17; BOT Report 12-A-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 INTRODUCTION

2
3 At the 2017 Annual Meeting, the American Medical Association (AMA) House of Delegates
4 (HOD) referred Resolution 212-A-17, submitted by the American College of Legal Medicine
5 (ACLM). The resolution asked that our AMA:

6
7 Join the American College of Legal Medicine to advocate federally-mandated interfaces
8 between provider/dispenser electronic health record systems in the clinical, hospital and
9 pharmacy environments and state prescription drug databases and/or prescription drug
10 management plans;

11
12 Advocate that the cost of generating these interfaces be borne by the commercial EHR and
13 dispensing program providers;

14
15 Advocate that the interface should include automatic query of any opioid prescription, from a
16 provider against the state prescription drug database/prescription drug management plan
17 (PDMP) to determine whether such a patient has received such a medication, or another
18 Schedule II drug from any provider in the preceding ninety (90) days;

19
20 Advocate that the prescriber and the patient's EHR-listed dispensing pharmacy should then be
21 notified of the existence of the referenced patient in the relevant PDMP database, the substance
22 of the previous prescription(s) (including the medication name, number dispensed and
23 prescriber's directions for use) in real time and prior to the patient receiving such medication;

24
25 Advocate that the electronic record management program at the pharmacy filling the relevant
26 prescription, contemporaneously as it enters the filling of the prescription by the pharmacist,
27 likewise be required to automatically query the state PDMP as a secondary mechanism to
28 prevent inappropriate prescribing, forgery, duplication and/or too great a frequency of use of
29 the involved controlled medication;

30
31 Work with ACLM and other concerned societies to urge Congress to timely enact and
32 implement such a statutory scheme supported by a workable and concise regulatory
33 framework, chiefly concentrating on the interfacing of all applicable electronic health record
34 and pharmaceutical dispensing systems with every individual state's PDMP, thereafter
35 designating a timeframe wherein all treating providers and dispensing pharmacists would be

1 required to perform such queries, in concert with the routine ordering of and filling of a
2 controlled substance to be used in the treatment of patients;

3
4 Advocate that oversight of the appropriate prescribing of and filling of prescriptions for
5 controlled substances remain with the involved individual federal and state criminal law
6 enforcement agencies, the involved state departments of health, or similar entities and the
7 involved relevant state provider and/or pharmacy licensure authorities; and

8
9 Advocate that statistics be maintained and reviewed on a periodic basis by state PDMP
10 personnel and relayed to state departments of health or agencies similarly situated so as to
11 identify and possibly treat those patients identified through this screening mechanism as
12 potential drug abusers and/or at risk of addiction.

13
14 Board of Trustees (BOT) Report 12-A-18 summarized work that the AMA has done in support of
15 ensuring accurate, reliable Prescription Drug Monitoring Programs (PDMPs) that support clinical
16 decision-making. It also addressed many of the complexities raised in the original resolution,
17 including evolution of PDMPs, and their integration with electronic health records (EHRs) and
18 electronic prescribing of controlled substances (EPCS).

19
20 After debate, the HOD referred BOT Report 12-A-18 back for consideration. While general
21 support existed for the recommendations contained in the report, the HOD asked for additional
22 information on the evolution of PDMPs. This report, therefore, updates and expands upon the
23 information in BOT Report 12-A-18 and presents amended policy recommendations.

24 25 DISCUSSION

26
27 More than 300 million queries of state PDMPs were made in 2017, more than doubling the 136
28 million queries in 2016, and five times the 61 million queries submitted in 2014.¹ Physician
29 adoption of EHRs also continues to grow. The Office of the National Coordinator for Health
30 Information Technology maintains that nearly 90 percent of office-based physicians are using
31 EHRs.²

32
33 A major goal of AMA advocacy and many others continues to be the integration of electronic
34 systems that can support efforts to address the opioid epidemic. To effectively support physician
35 and public health efforts to prevent opioid overdose deaths, the AMA has urged that electronic
36 systems be interoperable and integrated into medical practice workflows. As noted in BOT
37 Report 12-A-18, information exchanged with EHRs is not well incorporated into the physician's
38 workflow. Obtaining important information, including PDMP data, often requires multiple
39 "clicks," opening multiple windows, and the use of separate logins even before the physician
40 locates what he or she is looking for—and that situation must be repeated for each patient and
41 every prescription for a controlled substance. Effective PDMP and EHR integration means that the
42 workflow must achieve "functional interoperability," or the ability for systems to exchange,
43 incorporate and display data in a meaningful and contextual manner.

44
45 The Centers for Medicare & Medicaid Services highlighted this in a recent letter to state Medicaid
46 directors, noting that when integration occurs, it "removes the requirement for providers to log in to
47 a separate system, manage a separate log in, and disrupt their workflow to query the PDMP. Single
48 sign-on interoperability between EHR and PDMP such that PDMP results are displayed when the
49 EHR indicates a controlled substance is prescribed could be supported, as an example."³

1 Many consider the ideal practice to be a “one-click” solution with PDMP data and EPCS integrated
2 into physicians’ EHR systems. On one hand, many EHR vendors are pulled in too many directions
3 to focus on this need. Federal regulations require vendors to develop EHRs that meet
4 administrative requirements. To achieve the ideal for PDMP and EPCS integration, more must be
5 done to reduce the regulatory pressure on health IT development, allowing vendors the flexibility
6 to respond to physician and patient needs, rather than spending the bulk of their time complying
7 with administrative demands.

8
9 Yet, there have been reports of progress of successful PDMP-EHR integration. For example, the
10 University of North Carolina (UNC) Health Care at Chapel Hill, reported that efforts to integrate
11 its Epic EHR with the state PDMP have been positive. A news report from July found that “[i]n the
12 first two weeks, more than 540 UNC clinicians used the PDMP when treating some 2,950 patients,
13 which officials said has saved physicians about 119 hours already.”⁴ Oschner Health System in
14 New Orleans, Louisiana, also has used Epic to integrate the EHR with the state PDMP.⁵ Deaconess
15 Health, which operates several hospitals in Indiana, also has made strides to integrate EHRs with
16 the state PDMP. And there are many different options in the commercial market, although your
17 Board notes that a Google search of effective PDMP-EHR integration efforts results in dozens of
18 options.⁶

19
20 In addition to growing physician use of PDMPs, interstate interoperability has expanded
21 considerably. According to the National Association of Boards of Pharmacy, 44 states now can
22 securely share PDMP information across state lines.⁷ The effects of expanded PDMP use on patient
23 care are mostly unknown; physicians and other health care professionals are not the only ones
24 interested in using the PDMP data.

25
26 As noted above, PDMP use among physicians and other health care professionals has significantly
27 increased in recent years; however, opioid-related mortality continues to increase, driven
28 principally by heroin, illicit fentanyl, and other synthetic derivatives. Moreover, as PDMP use
29 increases and opioid prescribing rates decrease, it is not clear that PDMPs are making a significant
30 impact on improving patients’ pain care. One review concluded that “[e]vidence that PDMP
31 implementation either increases or decreases nonfatal or fatal overdoses is largely insufficient, as is
32 evidence regarding positive associations between specific administrative features and successful
33 programs. Some evidence showed unintended consequences. Research is needed to identify a set of
34 “best practices” and complementary initiatives to address these consequences.”⁸

35
36 There may also be a need for additional clarity on how PDMP data may be used by non-health care
37 professionals, including health insurance companies, pharmacy benefit management companies
38 (PBMs), and law enforcement. For example, earlier this year, the U.S. Department of Justice and
39 48 attorneys general reached an agreement to share data. According to the news release, “Drug
40 Enforcement Agency DEA will provide the Attorneys General with that data, and the states will
41 provide their own information, often from prescription drug monitoring programs (PDMPs) to
42 DEA. Under the agreement, both state and federal law enforcement will have more information at
43 their disposal to find the tell-tale signs of crime.” It is not clear what these “tell-tale signs” might
44 be.

45
46 Progress has been considerably slower in achieving EPCS uptake,⁹ largely due to outdated
47 regulations from the DEA. The combination of personal identification numbers (PINs), passwords,
48 and biometrics required to meet DEA standards for “two-factor authentication” increase EPCS
49 security but add to workflow disruptions and increase costs. DEA, EPCS requirements include
50 onerous limits on use of biometric devices, which must comply with federal standards that set an
51 unnecessarily high bar and prevent use of user-friendly consumer electronics already found in

1 physicians' offices for two-factor authentication. The biometric fingerprint scanners found on these
2 consumer devices, i.e., smart phone, tables, and laptop computers, are used for secure access to
3 other sensitive information, like banking and medical records, but typically do not comport with
4 rigid rules for EPCS.

5
6 The AMA views EPCS as important to support high-quality patient care. Physicians commonly
7 report that they are frustrated that they can e-prescribe non-controlled substance medications but
8 must still use written prescriptions for controlled substances. More than 70 percent of physicians
9 are e-prescribing non-controlled drugs but only 20 percent used EPCS. One reason for this is due to
10 the fact that not all EHR vendors understand or can satisfy EPCS requirements—state EPCS
11 mandates have increased uptake, but implementation has been delayed due to questions about
12 system certification, cost to providers, and patient concerns, i.e., transferring prescriptions between
13 pharmacies. Moreover, EHR vendor processes for EPCS do not always align well with normal
14 e-prescribing workflows—often physicians must start new computer programs and windows each
15 time they use EPCS. Cumbersome workflows and applications that do not take physician needs
16 into account impede EPCS uptake. Finally, although EPCS reduces prescription fraud and
17 diversion, it is less clear how it affects valid prescriptions for opioid analgesics. For example, does
18 the prescriber using EPCS put in a dose and duration or are numbers suggested by the EPCS
19 system and, if so, how are these amounts derived? These are among the questions the AMA has
20 been asking from vendors and physicians.

21
22 To help resolve other barriers, the AMA and the President's Commission on Combating Drug
23 Addiction and the Opioid Crisis have recommended the DEA modify EPCS regulations in order to
24 reduce barriers to EPCS adoption. The AMA asked DEA to reexamine the scope of technology that
25 is compliant with EPCS requirements and allow use of lower-cost, high-performing biometric
26 devices in two-factor authentication. The AMA also believes that there must be further study to
27 evaluate the variations in how EPCS systems handle initial dosing, i.e., are opioid doses or
28 durations auto-populated in EPCS systems and, if so, are the amounts appropriate.

29
30 A final point is that the AMA has made clear to the DEA that its requirements for biometric
31 devices limit user-friendly consumer electronics already found in physicians' offices, such as
32 fingerprint readers on laptop computers and mobile phones, from being utilized for two-factor
33 authentication in EPCS. This and other rules contribute to cumbersome workflows and applications
34 which are an impediment to physician EPCS uptake. Encouraging EPCS uptake and
35 interoperability of PDMP databases and electronic health records would improve the integration of
36 controlled substance use data into practice workflows and clinical decision-making.

37
38 The AMA also continues its efforts in support of making PDMPs better clinical tools. The use of
39 PDMPs continues to increase in states regardless of mandates—tied mainly to quality of the PDMP
40 as a decision-support tool in those states without mandates. Important policies that have improved
41 PDMP workflow and data reliability include delegate access, data input by pharmacists within
42 24 hours, and states sharing PDMP information. PDMP usability continues to improve, but usage
43 in rural and other areas may be affected by lack of access to broadband and other technologies.
44 Consistent, long-term funding of state PDMPs is also a concern—most states depend on federal
45 grants for ongoing maintenance and improvements. The AMA also continues to try and identify
46 best practices in designing PDMPs to identify risk including: distinguishing between uncoordinated
47 care, misuse, and “doctor shopping,” identifying opportunities for referrals to specialized care;
48 providing reports to prescribers to better inform prescribing decisions; and conducting public
49 health surveillance activities.¹⁰

1 One best practice is PDMP and EHR integration, but, as previously discussed, that goal remains
2 largely elusive. It is not clear, for example, how many PDMPs are integrated into EHRs, which
3 makes identification of best practices challenging given the variety of EHR systems in use. Each
4 state PDMP may require a slightly different interface to connect to an EHR. With over 600
5 different EHRs on the market, the number of custom EHR/PDMP interfaces required can reach into
6 the thousands. Custom software development is time-consuming and expensive—with costs being
7 passed on to the physician. Without PDMP and EHR integration, physicians must use multiple
8 usernames and passwords to shuttle between different systems, often having to re-enter login
9 information if one system times out while they are using the other one. This results in increased
10 time to enter information, decreased satisfaction with the technology, and potentially less use of the
11 systems.

12
13 Furthermore, the AMA notes that one dominant PDMP developer is responsible for the PDMP
14 platforms of more than 40 states. PDMP quality and uptake has improved and it is clear that the
15 PDMP interface is moving toward greater integration through the use of more advanced tools
16 offered by the developer.¹¹ This development, along with the growing interstate interoperability has
17 led, anecdotally, to physicians receiving a greater number of alerts about potentially dangerous
18 drug combinations, multiple prescriber events, and other clinical issues. Yet, these advanced tools
19 are not without costs, and it is not clear how these tools may be affecting patient care. The PDMP
20 interface can help identify a patient's prescription history, but that is only one component of
21 effectively screening a patient for a potential substance use disorder or helping understand whether
22 a patient's pain is being effectively managed.

23
24 Similarly, while there are some positive examples with PDMP-EHR integration, EHRs are
25 generally not interoperable between different organizations, making coordination between primary
26 care physicians, pain medicine physicians, addiction medicine physicians and other providers much
27 more difficult. When PDMP and EHR integration does exist (e.g., Oregon's EDIE), the patient,
28 public health and cost utilization benefits are extremely positive.¹² This integration requires time
29 and broad, institutional support. For example, the state of Washington's integration project with the
30 state Health Information Exchange (HIE) began in 2012. As of August 2017, more than 90 percent
31 of emergency departments include PDMP data in the EHR using data through the HIE.¹³ The
32 state's major health systems still are working to accomplish this integration.

33
34 To help resolve some of these issues, the AMA advocates for consistent and sufficient
35 appropriations to support a state's ability to maintain and improve its PDMP, including broad state-
36 based grants to improve statewide HIEs and the ability to integrate HIE data into the EHR of
37 statewide emergency departments and other providers. The AMA also would support a U.S.
38 Government Accountability Office study on best practices for small and large physician practices
39 on using PDMPs to improve pain care as well as treatment for substance use disorders. This would
40 include identifying how PDMPs can distinguish uncoordinated care from misuse or "doctor
41 shopping" as well as help coordinate care for a patient with a substance use disorder or other
42 condition requiring specialty care. In addition, a need exists to evaluate the variations in state-based
43 PDMP technology and work with the health IT industry to discuss "common understanding" of
44 how each PDMP works—providing transparency for EHR vendors to facilitate development of
45 custom connections between their products and PDMP software. This could include funding for
46 programs that pilot test low-cost technologies to better integrate EHRs and PDMPs as well as
47 efforts to identify burdensome federal regulations that prevent EHRs from being designed and
48 developed to support objective clinical decision-making.

49
50 The AMA also has been engaged in the SMART project to help EHR systems work better for
51 physicians and patients. A key component of this effort is the development of a flexible

1 information infrastructure that allows for free, open development of plug and play applications
2 (apps) to increase interoperability among health care technologies, including EHRs, in a more cost-
3 effective way. The infrastructure development specific to PDMPs is part of both ongoing research
4 as well as work by states working to achieve more comprehensive data integration.¹⁴ In addition,
5 the Office of the National Coordinator for Health Information Technology has compiled multiple
6 sources and pilot examples for PDMP and EHR integration.¹⁵ The pilot examples, not surprisingly,
7 found that PDMPs were most helpful when they were integrated into physicians' workflow as well
8 as EHRs.

9 10 AMA POLICY

11
12 The AMA House of Delegates has provided strong guidance to the AMA that reflects the issues
13 raised by the original resolution that is the subject of this report. Relevant policies include:

14
15 Policy H-120.957, "Prescription of Schedule II Medications by Fax and Electronic Data
16 Transmission," which "encourages the Drug Enforcement Administration to support two factor
17 authentication that is easier to implement than the current DEA and EPCS security requirements;
18 and because sufficient concerns exist about privacy and confidentiality, authenticity, and other
19 security measures, does not support the use of "hard copy" facsimile transmissions as the original
20 written prescription for Schedule II controlled substances, except as currently allowed in Section
21 1306 of Title 21 of the Code of Federal Regulations."

22
23 In addition, Policy H-95.928, "Model State Legislation Promoting the Use of Electronic Tools to
24 Mitigate Risk with Prescription Opioid Prescribing," provides that the AMA support multiple
25 facets of PDMP development, including interoperability, assisting physicians and pharmacists in
26 identifying "when their patients have received a prescription for controlled substances from
27 multiple prescribers or multiple pharmacies within a short time frame."

28
29 Policy D-478.972, "EHR Interoperability," calls for the AMA to continue efforts in support of
30 EHR interoperability standards, reducing excessive costs and generally reducing barriers to EHR
31 adoption.

32
33 Finally, Policy D-478.994, "Health Information Technology," broadly notes AMA support for
34 "legislation and other appropriate initiatives that provide incentives for physicians to acquire health
35 information technology," which reasonably would include PDMP EPCS and EHR uptake.

36 37 RECOMMENDATIONS

38
39 The Board of Trustees recommends that the following recommendations be adopted in lieu of
40 Resolution 212-A-17, and the remainder of the report be filed:

- 41
42 1. That our American Medical Association (AMA) advocate for a federal study to evaluate the
43 use of PDMPs to improve pain care as well as treatment for substance use disorders. This
44 would include identifying whether PDMPs can distinguish team-based care from
45 uncoordinated care, misuse, or "doctor shopping," as well as help coordinate care for a patient
46 with a substance use disorder or other condition requiring specialty care. (Directive to Take
47 Action)
48
49 2. That our AMA urge EHR vendors to increase transparency of custom connections and costs for
50 physicians to integrate their products in their practice. (Directive to Take Action)

- 1 3. That our AMA support state-based pilot studies of best practices to integrate EHRs, EPCS and
2 PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such
3 integration from occurring. (New HOD Policy)

Fiscal Note: Less than \$500

REFERENCES

- ¹ Data collected by the AMA from state PDMP administrators. See <https://www.end-opioid-epidemic.org/wp-content/uploads/2018/05/AMA2018-OpioidReport-FINAL-updated.pdf>
- ² Office of the National Coordinator for Health Information Technology. 'Office-based Physician Electronic Health Record Adoption,' Health IT Quick-Stat #50. dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php. December 2016.
- ³ CMS letter to state Medicaid Directors, June 11, 2018. Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf>
- ⁴ <https://www.healthcareitnews.com/news/opioid-epidemic-unc-health-care-integrate-epic-ehr-states-pdmp>
- ⁵ <https://www.healthcareitnews.com/news/ochsner-integrates-opioid-monitoring-tool-its-epic-ehr>
- ⁶ Additional efforts in the commercial market to better integrate PDMP use into clinical workflow and integrate with EHRs include PMP Gateway from Appriss Health (<https://apprisshealth.com/solutions/pmp-gateway/>), web-based apps using SMART on FHIR protocols (<https://apps.smarthealthit.org/app/rxorbit-inworkflow-app>), a product from Allscripts (https://allscriptsstore.cloud.prod.iapps.com/applications/id-17010/LogiCoy_PDMP), to name a few.
- ⁷ National Association Boards of Pharmacy. Available at <https://nabp.pharmacy/initiatives/pmp-interconnect/>
- ⁸ Fink DS, Schleimer JP, Sarvet A, Grover KK, Delcher C, Castillo-Carniglia A, et al. Association Between Prescription Drug Monitoring Programs and Nonfatal and Fatal Drug Overdoses: A Systematic Review. *Ann Intern Med*. 2018;168:783–790. doi: 10.7326/M17-3074. Available at <http://annals.org/aim/article-abstract/2680723/association-between-prescription-drug-monitoring-programs-nonfatal-fatal-drug-overdoses>
- ⁹ Surescripts. Electronics Prescribing for Controlled Substances. Available at <http://surescripts.com/products-and-services/e-prescribing-of-controlled-substances>
- ¹⁰ PDMP TTAC. Prescription Drug Monitoring Training and Technical Center. Tracking PDMP Enhancement: The Best Practices. Available at http://www.pdmpassist.org/pdf/2016_Best_Practice_Checklist_Report_20170228.pdf
- ¹¹ Appriss Health Gateway explained at <https://apprisshealth.com/solutions/pmp-gateway/>
- ¹² ACEPNow. Emergency Department Information Exchange Can Help Coordinate Care for Highest Utilizers. Available at <http://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/2/>
- ¹³ Status of the Integration of Electronic Health Records Systems with the Prescription Monitoring Program Under ESHB 1427. Available at <https://www.doh.wa.gov/Portals/1/Documents/2300/2017/1427EMR-IntegReport.pdf>
- ¹⁴ See, for example, Sinha, Shyamashree, et al. “Safe opioid prescription: a SMART on FHIR approach to clinical decision support.” *Online J Public Health Inform*. 2017; 9(2): E193. Published online 2017 Sep. 8. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5630280/>; Wisconsin Interactive Network. “Prescription Drug Monitoring Program & Electronic Health Record Integration Technical Specifications.” Available at http://www.portal.wi.gov/register/Documents/PDMP_EHR_Integration_Technical_Specifications.pdf
- ¹⁵ PDMPConnect. Office of the National Coordinator for Health Information Technology. Available at <https://www.healthit.gov/pdmp/PDMPConnect>

REPORT OF THE BOARD OF TRUSTEES

B of T Report 8-I-18

Subject: 340B Drug Discount Program
(Resolution 225-A-18 Resolve 3)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

INTRODUCTION

At the 2018 Annual Meeting of the House of Delegates (HOD), the third resolve of Resolution 225-A-18 was referred for report back at the 2018 Interim Meeting. Resolution 225-A-18, sponsored by American Society of Clinical Oncology (ASCO), asked that our American Medical Association (AMA):

(3) support discontinuing the use of the Disproportionate Share Hospital (DSH) adjustment as a determining measure for 340B program eligibility;

The reference committee heard mixed testimony on this resolve. Testimony was offered that additional research and analysis is needed to assess how to identify the DSH hospitals that should not benefit from 340B program rebates and those that should. The reference committee recommended adopting Resolves 1, 2, and 4, and referral of Resolve 3 for a report back at the 2018 Interim Meeting.

AMA POLICY

Our AMA has an extensive policy that supports increased pharmaceutical drug and biological affordability and policies to ensure patient access to medically necessary prescription medication. However, our AMA does not have specific policy concerning the 340B program other than the HOD adopted resolves of Resolution 225-A-18 (Policy H-110.985, “340B Drug Discount Program”). There is a policy related to rebates which provides that our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. (Policy H-110.987, “Pharmaceutical Cost”). Thus, there is support for rebate programs to the extent such programs benefit underinsured patients and patients living on low-incomes. Consistent with the foregoing, AMA policy provides support for the subsidization of prescription drugs for Medicare patients based on means testing (Policy H-330.902, “Subsidizing Prescription Drugs for Elderly Patients”). However, AMA policy also includes support for economic assistance, including coupons (and other discounts), for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured (Policy H-125.977, “Non-Formulary Medication and the Medicare Part D Coverage Gap”).

BACKGROUND

The 340B program, which is administered by the U.S. Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA), requires pharmaceutical manufacturers to sell outpatient prescription medication at a discount to covered entities. Congress established the 340B program in order to produce savings for certain safety-net health care providers by allowing them to purchase outpatient drugs at these discounted prices.¹ The U.S. House of Representatives' report, accompanying the original legislation, stated that these savings would "enable [participating] entities to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."² Pharmaceutical manufacturers are required to enter into an agreement, called a pharmaceutical pricing agreement (PPA), with the HHS Secretary. Under the PPA, the manufacturer agrees to provide front-end discounts on covered outpatient prescription medication purchased by "covered entities."

The 340B program definition of "covered entity" includes six categories of hospitals: (1) disproportionate share hospitals (DSHs); (2) children's hospitals; (3) cancer hospitals exempt from the Medicare prospective payment system; (4) sole community hospitals; (5) rural referral centers; and (6) critical access hospitals (CAHs).³ In addition, to qualify hospitals must be (1) owned or operated by state or local government, (2) a public or private non-profit corporation which is formally granted governmental powers by state or local government, or (3) a private non-profit organization that has a contract with a state or local government to provide care to low-income individuals who do not qualify for Medicaid or Medicare.⁴ Also, hospitals must meet payer-mix criteria related to the Medicare DSH program with the exception of CAHs.⁵ There are also 11 categories of non-hospital covered entities that are eligible based on receiving federal funding that include: federally qualified health centers (FQHCs); FQHC "look-alikes;" state-operated AIDS drug assistance programs; Ryan White Comprehensive AIDS Resources Emergency Act clinics and programs; tuberculosis, black lung, family planning, and sexually transmitted disease clinics; hemophilia treatment centers; Title X public housing primary care clinics; homeless clinics; urban Indian clinics; and Native Hawaiian health centers.⁶ Covered entities may provide drugs purchased through the 340B program to all eligible patients, regardless of a patient's payer status and whether the drug is intended for self-administration or administration by a clinician. Discounts have been estimated to range from 20-50 percent of the drug's cost.⁷

DISCUSSION

Affordability and access to prescription medication is an area of increased focus by Congress and the Trump Administration. In the past year the 340B program has become the subject of significant scrutiny. A central question posed by a number of stakeholders: do the rapidly increasing number of DSH hospitals eligible for the 340B program discounts provide low-income patients the benefit of the prescription drug rebates that they receive? (Other aspects of the 340B program, addressed by the newly adopted AMA policy concerning the 340B program, have also been flagged including manufacturer and covered entity noncompliance with 340B program requirements and insufficient federal agency authority and resources to provide appropriate oversight.)

The Affordable Care Act increased the size and scope of the 340B program by expanding eligibility to more types of hospitals, such as critical access hospitals and sole community hospitals, and expanded Medicaid eligibility. As a result of the latter, the number of hospitals qualifying as DSH hospitals increased as DSH designation is calculated based on a formula that utilizes the number of Medicaid covered patients that a hospital serves. The number of participating unique covered entities has grown from 3,200 in 2011 to 12,722 in October 2017.⁸ The number of hospitals has grown significantly, from 591 in 2005 to 2,479 as of October 2017.⁹

1 There have also been a number of unintended consequences of the 340B program. A 2015 Avalere
2 study found that hospitals participating in the 340B program were more likely than non-340B
3 hospitals to acquire independent physician practices.¹⁰ These acquisitions create financial windfalls
4 for hospitals due to the 340B program yet do not necessarily improve affordability for patients.
5 Patient costs and resultant co-pays/co-insurance and deductibles for care in a hospital outpatient
6 department (HOPDs) can be higher than those in physician offices.¹¹ (In those instances, patient
7 care in HOPDs is more costly for health insurers too.) Furthermore, some 340B eligible hospitals
8 may have commercial contracts that pay substantially more than the Medicare rate for drugs,¹² so
9 the profit margin can be multiples of the cost of the drug. Patients may face a 20 percent
10 coinsurance on this higher amount. Yet, hospitals eligible for the 340B program obtain drugs at a
11 substantial discount. The 340B program does not require that the hospital pass the savings to
12 uninsured or underinsured low-income patients. To the extent that the hospital does not pass along
13 the savings, the combined payment by insurer and patient provides profit for the 340B hospital; the
14 additional volume generated when 340B hospitals acquire independent physician practices results
15 in even greater profits. There are also reports that hospital systems have acquired 340B program
16 eligible hospitals in order to purchase drugs for their suburban clinics utilizing the discounts even
17 though such clinics do not serve uninsured or underinsured low-income patients.

18
19 There have been several congressional hearings on the 340B program convened by the U.S.
20 Senate's Health, Education, Labor, and Pension (HELP) Committee as well as the U.S. House of
21 Representatives' Energy and Commerce (E&C) Committee. Testimony offered by the U.S.
22 Government Accountability Office (GAO),¹³ the HHS Office of the Inspector General (OIG),¹⁴ and
23 other witnesses included concerns with the 340B program's: (1) inadequate "patient" definition;
24 (2) eligibility criteria for covered entity; (3) oversight of covered entities and manufacturers; and
25 (4) oversight of the use of contract pharmacies. The lack of program data to assess the extent to
26 which 340B program covered entities are ensuring low-income patients benefit from the rebates
27 and the savings has particularly troubled policymakers and other stakeholders.

28
29 In addition to the hearings, over 17 federal bills have been introduced concerning the 340B
30 program in this Congress. A number of the bills would mandate reporting on care provided to low-
31 income individuals and would impose new eligibility requirements for certain categories of
32 covered entities. For example, in December 2017, Representative Larry Buschon (R-IN) introduced
33 H.R. 4710, Protecting Access for Underserved and Safety-net Entities Act (340B PAUSE Act). The
34 bill would impose a moratorium on registration for certain new 340B program hospitals and
35 associated sites. H.R. 4710 would also mandate data collection by covered entities including the
36 number and percentage of insured (by insurer) and uninsured individuals who are dispensed or
37 administered 340B program discounted drugs. In January 2018, Senator Bill Cassidy (R-LA)
38 introduced S. 2312, Helping Ensure Low-income Patients have Access to Care and Treatment Act
39 (HELP Act). The bill would impose a registration moratorium on new non-rural 340B program
40 covered entities and associated sites as well as new eligibility requirements for covered entities. It
41 would also require reports on the level of charity care provided by covered entities. Similarly, in
42 April 2018, Representative Earl Carter (R-GA) introduced H.R. 5598, 340B Optimization Act. The
43 bill would amend the Public Health Service Act to require certain disproportionate share hospital
44 covered entities under the 340B drug discount program submit to HHS reports on low-income
45 utilization rates of outpatient hospital services furnished by such entities.

46
47 In order to address the lack of data available directly from 340B program hospital covered entities
48 or HRSA vis-à-vis the benefit to low-income patients, the House E&C Committee Chairman Greg
49 Walden (R-OR) and health subcommittee Chairman Michael Burgess (R-TX) requested a report on
50 the topic from the GAO. On June 18, 2018, the GAO issued the report, Drug Discount Program:

Characteristics of Hospitals Participating and Not Participating in the 340B Program. The report found that:

[i]n 2016 ... the median amount of charity care provided by all 340B hospitals ... was similar to the median amount provided by all non-340B hospitals, and the median amount of uncompensated care provided by these 340B hospitals was higher than that provided by their non-340B counterparts. But again, the differences between the 340B and non-340B hospitals varied across the different hospital types. For example, while the median amount of uncompensated care provided by 340B general acute care hospitals (340B DSH) was higher than that of their non-340B counterparts, the median amount provided by 340B CAHs was lower than that of non-340B CAHs.

While the report provides additional needed analysis and data, more information is needed concerning the program's implementation and benefit to low income patients. To ensure the 340B program covered entity criteria aligns with the goal of ensuring low income patients are able to access affordable treatments, at least one national medical specialty society has recommended that Congress establish new metrics that such entities must meet that are objective, universal, verifiable and align program eligibility with the care provided by the covered entity to indigent and underserved individuals. Consistent with the foregoing, alternative eligibility measures could be calculated by analyzing the amount of charity care provided by hospitals in the outpatient setting. Ultimately, eligibility should be designed to qualify entities based on the amount of care delivered to underserved populations in outpatient settings. This would dovetail with new AMA policy to work with policymakers to establish 340B program eligibility for all physician practices demonstrating a commitment to serving low-income and underserved patients, new covered entity criteria should promote participation by institutions and practices of all sizes in all settings. To advance this goal, ASCO has convened an expert workgroup to develop recommendations for a revised eligibility formula in order to appropriately capture the level of outpatient charity care provided by hospitals, as well as standalone community practices. ASCO will provide policymakers and other stakeholders with the recommendations during the current congressional session.

CONCLUSION

The significant growth of the 340B program, particularly among DSH hospitals, should align with newly adopted HOD policy concerning 340B program and related AMA policies. Specifically, the program should promote access to affordable prescription drugs by low-income patients receiving care from 340B program covered entities. In addition, our AMA should engage with national medical specialty societies to leverage expertise and align recommendations to federal policymakers.

RECOMMENDATIONS

In light of these considerations, your Board of Trustees recommends that the following recommendations be adopted in lieu of the third resolve Resolution 225-A-18 and the remainder of this report be filed:

1. That our American Medical Association support a revised 340B drug discount program covered entity eligibility formula, which appropriately captures the level of outpatient charity care provided by hospitals, as well as standalone community practices. (New HOD Policy)

- 1 2. Our AMA will confer with national medical specialty societies on providing policymakers with
2 specific recommended covered entity criteria for the 340B drug discount program. (Directive
3 to Take Action)

Fiscal Note: Less than \$5000

REFERENCES

¹ Section 340B of the Public Health Service Act, codified at 42 U.S.C. § 256b.

² H.R. Rept. No. 102-384 (Part 2), at 12 (1992) (Conf. Rept.).

³ 42 U.S.C. § 256b(a)(4)(A)–(K)

⁴ Id.

⁵ Id.

⁶ Id.

⁷ Statement of Debra A. Draper Director, Health Care, GAO, July 18, 2017, U.S. House of Representatives, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce hearing on Drug Discount Program, Updated on Agency Efforts to Improve 340B Program Oversight, Available from <https://www.gao.gov/assets/690/685903.pdf>

⁸ Review of the 340B Drug Pricing Program, U.S. House of Representatives Energy and Commerce Committee. Available from: https://energycommerce.house.gov/wp-content/uploads/2018/01/20180110Review_of_the_340B_Drug_Pricing_Program.pdf

⁹ Id.

¹⁰ Hospital Acquisitions of Physician Practices and the 340B Program, June 2015, Available from <http://340breform.org/userfiles/Avalere%20Acquisition.pdf>; and, National Patient Advocate Foundation’s Response to Additional Questions for the Record Relating to the Hearing Entitled “Examining Reforms to Improve the Medicare Part B Drug Program for Seniors” July 2013, Available from <https://docs.house.gov/meetings/IF/IF14/20130628/101055/HHRG-113-IF14-Wstate-Davenport-EnnisN-20130628-U4.pdf>

¹¹ An Avalere report on Cost of Cancer Care stated that its “risk-adjusted results suggest that treatment for patients receiving chemotherapy in a HOPD costs on average 24 percent more than treatment received in a physician’s office.” Available from <http://www.communityoncology.org/pdfs/avalere-cost-of-cancer-care-study.pdf>

¹² Physician-administered Drugs: Comparison of Payer Payment Methodologies, U.S. Government Accountability Office, August 2016, Available at <https://www.gao.gov/assets/680/678784.pdf>

¹³ Statement of Debra A. Draper, Director, Health Care, GAO, May 15, 2018, U.S. Senate Committee on Health, Education, Labor, and Pensions hearing on Examining Oversight Reports on the 340B Drug Price Program.

¹⁴ Testimony of Ann Maxwell, Assistant Inspector General for Evaluation and Inspections, OIG HHS, May 15, 2018, U.S. Senate Committee on Health, Education, Labor, and Pensions hearing on Examining Oversight Reports on the 340B Drug Price Program.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-I-18

Subject: Violence Prevention
(Resolution 419-A-18, Resolves 1 and 3)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 INTRODUCTION

2
3 Resolution 419-A-18, “Violence Prevention,” was introduced by the Washington Delegation. The
4 first and third Resolves, which were referred by the House of Delegates, asked:

5
6 That our American Medical Association (1) advocate that a valid permit be required before the
7 sale of all rapidly-firing semi-automatic firearms and (3) study options for improving the
8 mental health reporting systems and patient privacy laws at both the state and federal levels
9 and how those can be modified to allow greater information sharing between state and federal
10 government, law enforcement, schools and mental health professionals to identify, track and
11 share information about mentally ill persons with high risk of violence and either report to law
12 enforcement and/or the National Instant Criminal Background Check System, with appropriate
13 protections.

14
15 Accordingly, this report addresses both firearm licensing and mental health reporting
16 requirements.

18 CURRENT AMA POLICY

19
20 As one of the main causes of intentional and unintentional injuries and deaths, the American
21 Medical Association (AMA) recognizes that firearm-related violence is a serious public health
22 crisis in the United States. The AMA has extensive policy on firearm safety and violence
23 prevention. Relevant to this report is existing policy that supports requiring the licensing of firearm
24 owners, including completion of a required safety course and registration of all firearms. The AMA
25 also supports a waiting period and background check for all firearm purchasers.

26
27 AMA also supports (1) the establishment of laws allowing family members, intimate partners,
28 household members, and law enforcement personnel to petition a court for the removal of a firearm
29 when there is a high or imminent risk for violence; (2) requiring states to have protocols or
30 processes in place for requiring the removal of firearms by prohibited persons; (3) requiring gun
31 violence restraining orders to be entered into the National Instant Criminal Background Check
32 System; and (4) efforts to ensure the public is aware of the existence of laws that allow for the
33 removal of firearms from high-risk individuals.

BACKGROUND

Council on Science and Public Health Report 4-A-18, “The Physician’s Role in Firearm Safety,” reviewed the epidemiology of firearm morbidity and mortality, identified barriers to physician counseling, discussed the 11th U.S. Circuit Court of Appeals decision, which held that Florida’s Firearm Owners’ Privacy Act violated the First Amendment, explained that there are no state or federal laws that prohibit physicians from counseling patients on firearm safety, outlined the risk factors for firearm injuries, and identified policies that grant the authority to remove firearms from high-risk individuals who already possess them. Because these issues were recently addressed, they are not considered in this report. This report focuses on the issues of licensing of firearm purchasers and mental health reporting.

The National Instant Criminal Background Check System (NICS)

The Brady Handgun Violence Prevention Act of 1993 required the establishment of a computerized system to facilitate background checks on individuals seeking to acquire firearms from federally licensed firearms dealers. The NICS was activated in 1998 and is administered by the Federal Bureau of Investigation (FBI). In 2010, federal and state agencies conducted 10.4 million background checks and more than 150,000 purchases were denied when purchasers were identified as prohibited persons.¹ However, records in the NICS are provided voluntarily by state, local, tribal, and federal agencies. Inconsistencies in states’ reporting of disqualifying records to the NICS, as well as loopholes (i.e., unlicensed dealers) in the requirements for background checks prior to a firearm purchase, contribute to the lack of success in consistently identifying individuals who are disqualified from possessing firearms.

Prohibited Persons and Mental Health

The federal Gun Control Act (GCA) of 1968 makes it unlawful for certain categories of persons to ship, transport, receive, or possess firearms or ammunition. Those categories include, but are not limited to individuals convicted of a felony; unlawful users or those with addiction involving any controlled substance; individuals adjudicated as a “mental defective” or under an order of civil commitment; individuals subject to a court order restraining them from harassing, stalking, or threatening an intimate partner or child of the intimate partner; or persons who have been convicted of a misdemeanor crime of domestic violence. “Adjudicated as a mental defective” is further defined as:

A determination by a court, board, commission, or other lawful authority that a person, as a result of marked subnormal intelligence, or mental illness, incompetency, condition, or disease: (1) Is a danger to himself or to others; or (2) Lacks the capacity to manage his own affairs. The term shall include – (1) a finding of insanity by a court in a criminal case, and (2) those persons found incompetent to stand trial or found not guilty by lack of mental responsibility (under the Uniform Code of Military Justice).²

Furthermore, “committed to a mental institution” is defined as:

A formal commitment of a person to a mental institution by a court, board, commission, or other lawful authority. The term includes a commitment to a mental institution involuntarily. The term includes commitment for mental defectiveness or mental illness. It also includes commitments for other reasons, such as for drug use. The term does not include a person in a mental institution for observation or a voluntary admission to a mental institution.³

1 It is important to note that a diagnosis of, or treatment for, mental illness does not alone qualify an
2 individual for reporting to the NICS.^{4, 5} Existing federal criteria for firearm-disqualifying mental
3 health records are not perfect. They have been criticized for being both over-inclusive and under-
4 inclusive.⁶ It is the American Psychiatric Association's position that:

5
6 Reasonable restrictions on gun access are appropriate, but such restrictions should not be based
7 solely on a diagnosis of mental disorder. Diagnostic categories vary widely in the kinds of
8 symptoms, impairments, and disabilities found in affected individuals. Even within a given
9 diagnosis, there is considerable heterogeneity of symptoms and impairments.⁷

10
11 Furthermore, individuals with mental illness, when appropriately treated, do not pose an increased
12 risk of violence compared with the general population.⁸ However, mental illness is strongly
13 associated with suicide, which represents nearly 60 percent of firearm-related deaths in the United
14 States.

15 16 DISCUSSION

17 18 *State Licensing Requirements*

19
20 Federal law does not require the licensing of firearm purchasers or owners. A number of states
21 have enacted licensing requirements to help prevent prohibited individuals from purchasing
22 firearms. Different types of firearm licensing laws exist in states. Permits-to-purchase (PTP)
23 licensing systems require prospective firearm purchasers to have direct contact with law
24 enforcement or judicial authorities that review the purchase application and verify the passage of a
25 background check.⁹ While similar to PTP laws, license to own firearm laws differ in that the
26 license must remain valid for as long as the person owns the firearm. Firearm safety certificates
27 require completion of a required safety training course as a part of the firearm licensing process in
28 addition to the passage of a background check. Firearm registration laws require individuals to
29 record their ownership of a firearm with a designated law enforcement agency.

30
31 PTP laws, which have been enacted in 10 states and the District of Columbia, are the most common
32 type of firearm licensing laws.¹⁰ In these jurisdictions, both licensed and unlicensed dealers can
33 only sell firearms to individuals with a current PTP license, closing the loophole that exists under
34 federal law. While the licensing requirements vary by state, they generally require an individual to
35 fill out a license or permit application form, submit the form in-person to the licensing authority,
36 and pay the required fees. A background check through the NICS is usually required. Some states
37 also require fingerprints to be taken as a part of the application process. In some jurisdictions
38 (Massachusetts, New York and New Jersey), law enforcement agencies have discretion in denying
39 a permit. If approved, the permit or license is issued. State licensing laws usually apply to specific
40 types of firearms (i.e., handguns or long guns and rifles).

41
42 States with PTP laws tend to have lower firearm-related death rates than states without these laws
43 after controlling for demographic, economic and other differences across states.¹¹ Evidence
44 suggests that state laws leading to tighter regulation of sale and possession of firearms, including
45 PTP laws, reduce the availability of in-state guns involved in crimes and traced by law
46 enforcement.¹² Furthermore, criminals who used firearms in places with PTP laws typically
47 acquired them from states with weaker laws.¹³ PTP laws also are associated with reductions in
48 firearm homicide and suicide rates. Connecticut's PTP law was associated with a 40 percent
49 reduction in firearm homicide rates during the first 10 years the law was in place while there was
50 no evidence for a reduction in non-firearm homicides.¹⁴ Missouri's firearm-related homicide rate
51 increased abruptly after the state repealed its PTP handgun licensing law in 2007. The state saw a

25 percent higher rate in the first three years post repeal than during the prior nine years.¹⁵ A study conducted in large urban counties found that PTP laws were associated with a 14 percent reduction in firearm homicides.¹⁶ PTP law enactment was associated with protective effects against firearm suicides in Connecticut, and PTP repeal in Missouri was associated with increased risk of firearm suicides.¹⁷

Mental Health Reporting

In 2007, the NICS Improvement Amendments Act (NIAA) authorized the Attorney General to provide grants to states to improve electronic access to records and incentivize states to turn over records of persons prohibited from possessing firearms.¹⁸ The NIAA created the NICS Act Record Improvement Program (NARIP), which provides funding to states to ensure that the appropriate mental health records are included in the NICS. In November of 2011, a report by Mayors Against Illegal Guns found that for complex legal and logistical reasons, records of serious mental health and substance use problems that disqualify people from firearm ownership have been difficult to capture in NICS.¹⁹ In 2012, the Government Accountability Office examined states' progress in reporting mental health records to the NICS. They found that from 2004 to 2011, the total number of mental health records that states made available to the NICS increased by 800 percent – from 126,000 to 1.2 million records.²⁰ However, the increase largely reflected the efforts of 12 states. A variety of technological, coordination, and legal (i.e., privacy) challenges limit states' ability to report mental health records.²¹

Technological challenges are relevant to mental health reporting because the records originate from multiple sources within a state (i.e., courts, private hospitals, state mental health agencies) and are not captured by a single agency.²² In terms of legal challenges, some states indicated that the lack of explicit state-level authority to share mental health records with NICS was an impediment.²³ Coordination challenges involved getting hospitals and departments of mental health to collaborate with law enforcement, who make the majority of records available to NICS.²⁴ Non-criminal justice entities may not be aware of NICS reporting requirements, or, if they are aware, may be unfamiliar with how to report.

Relationship to NARIP Funding. NARIP funding has been provided to states to address these barriers. In order to receive NARIP funding, states are required to have a “relief from disabilities statute” whereby firearm purchasing rights can be restored to a person who had them removed because of a mental health adjudication or involuntary commitment. Information on the level of funding by state from FY 2009-2017, as well as promising practices for improved record reporting to the NICS, are available on the Bureau of Justice Statistics website.²⁵ As of July 2015, there were 3.8 million state-submitted mental health records in the NICS.²⁶ Forty-three states have enacted laws that require (32) or authorize (11) the reporting of mental health records to NICS. The largest increase in reported mental health data from 2008 to 2015 occurred in states with a reporting requirement.²⁷ Twenty of the 26 states with the largest increase in mental health data also received NARIP funding.

HIPAA Considerations. In 2013 there was considerable focus on whether the Health Insurance Portability and Accountability Act (HIPAA) or state privacy laws were an obstacle to the submission of mental health records to NICS.²⁸ On January 4, 2016, the U.S. Department of Health and Human Services modified HIPAA to expressly permit certain covered entities to disclose to the NICS the identities of those individuals who, for mental health reasons, are prohibited by federal law from having a firearm.²⁹ The final rule noted that creating a limited express permission in the HIPAA Privacy Rule to use or disclose certain information relevant to the federal mental health prohibitor for NICS purposes was necessary to address barriers related to HIPAA, and to ensure

1 that relevant information can be reported for this important public safety purpose. The rule
2 specifically prohibits the disclosure of diagnostic or clinical information from medical records or
3 other sources, and any mental health information beyond the indication that the individual is
4 subject to the federal mental health prohibitor, and does not apply to most treating providers.³⁰

5
6 Education Records. The Family Educational Rights and Privacy Act (FERPA) is a Federal law that
7 protects the privacy of student education records. Due to the nature of mental health records
8 reported to the NICS, schools are not likely to be among the organizations reporting. However,
9 FERPA does have an exception that allows educational agencies and institutions to disclose
10 personally identifiable information from education records to appropriate parties in connection with
11 an emergency if knowledge of the information is necessary to protect the health and safety of the
12 student or other individuals.³¹ The information may be disclosed to any person whose knowledge
13 of the information is necessary to protect the health or safety of the student or other individuals.

14 15 CONCLUSION

16
17 The AMA House of Delegates adopted policy at A-18 to require the licensing of all firearm
18 owners. PTPs are a type of license, thus a separate policy requiring a permit prior to the sale of
19 rapidly-firing semi-automatic firearms is not necessary. This requirement is encompassed in the
20 existing licensing policy. However, amending the policy to clarify that permits are a type of license
21 would be helpful to avoid future confusion.

22
23 In terms of mental health reporting, several national reports have identified the technological,
24 coordination, and legal (i.e., privacy) challenges that limit states' ability to report mental health
25 records to the NICS. In recent years, progress has been made to increase the reporting of these
26 records through the enactment of state reporting requirements, federal grants to states to address
27 collaboration through state level task forces focused on NICS improvement, training to help
28 identify the records that should be reported, automated transfer of mental health data to the NICS,
29 and clarification of federal privacy laws. In addition, legislation was enacted by Congress as part of
30 the FY 2018 Omnibus Appropriations bill—the Fix NICS Act of 2017—that, among other
31 provisions, requires states to develop a plan to ensure maximum coordination and automation of
32 the reporting the NICS.³² The law also reauthorizes NARIP through FY 2022.³³ While existing
33 AMA policy supports a waiting period and background checks for all firearm purchases, AMA
34 policy does not currently address deficiencies in the current NICS system.

35
36 In addition to the NICS system, it is important to have policies in place that remove current access
37 to firearms rather than just preventing the purchase of new firearms by individuals who are at high
38 or imminent risk for harming themselves or others. The Council on Science and Public Health
39 report and recommendations on “The Physician’s Role in Firearm Safety,” at A-18 led to the
40 adoption of policy addressing the removal of firearms from high risk individuals, which includes
41 support for gun violence restraining orders. Since overlapping policy on gun violence restraining
42 was adopted and appended to Policy H-145.996, “Firearm Availability.” We recommend
43 streamlining AMA policy in this area and removing the reference to “red flag” laws.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of the first and third resolves of Resolution 419-A-18 and the remainder of the report be filed.

1. That Policy H-145.996, "Firearm Availability" be amended by addition and deletion to read as follows:

H-145.996 Firearm Availability

1. Our AMA: (a) Advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA ~~policy is to~~ supports requiring ~~require~~ the licensing/permitting of ~~owners of~~ firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports granting local law enforcement discretion over whether to issue concealed carry permits. ~~in the permitting process in such that local police chiefs are empowered to make permitting decisions regarding "concealed carry", by supporting "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and by supporting "red flag" laws for individuals who have demonstrated significant signs of potential violence.~~ In supporting local law enforcement, we also support as well the importance of "due process" so that decisions could be reversible by individuals can petition petitioning in court for their rights to be restored. (Modify Current HOD Policy)

2. That Policy H-145.972, "Firearms and High-Risk Individuals" be reaffirmed.

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. (Reaffirm HOD Policy)

3. That our American Medical Association: (1) encourages the enactment of state laws requiring the reporting of relevant mental health records, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of mental health records to NICS to improve the quality and timeliness of the data. (New HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

- ¹ Frandsen RJ, Naglich D, Lauver GA. Background checks for firearm transfers, 2010 – Statistical Tables. Washington, DC. Bureau of Justice Statistics; 2013.
- ² 27 C.F.R. §478.11
- ³ 27 C.F.R. §478.11
- ⁴ Liu EC, Bagalman E, Chu VS, Redhead CS. Submission of Mental Health Records to NICS and the HIPAA Privacy Rule. Congressional Research Service. April 15, 2013.
- ⁵ Office of Civil Rights, DHHS, HIPAA Privacy Rule and NICS Final Rule. Federal Register. 2016. 81(3):382-396.
- ⁶ Swanson JW, McGinty EE, Fazel S, et al. Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. *Annals of Epi.* 2015; 25(5): 366-376. Volume 25, Issue 5, May 2015, Pages 366-376
- ⁷ American Psychiatric Association. Position Statement on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services. Accessed March 19, 2018.
- ⁸ Rueve ME, Welton RS. Violence and mental illness. *Psychiatry.* 2008;5: 34-48.
- ⁹ Webster DW, Vernick JS, and Hepburn LM. Relationship between licensing, registration, and other gun sales laws and the source state of crime guns. *Injury Prevention* 2001;7: 184-189.
- ¹⁰ Johns Hopkins Bloomberg School of Public Health, Center for Gun Safety. Permit to Purchase Licensing for Handguns. March 2015. Available at: https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-gun-policy-and-research/publications/FactSheet_PermittoPurchaseLicensing.pdf. Accessed August 1, 2018.
- ¹¹ Flegler EW, Lee LK, Monuteaux MC, Hemenway D, Mannix R. Firearm legislation and firearm related fatalities in the United States. *JAMA Intern Med.* 2013;173: 732-40.
- ¹² Collins T, Greenberg R, Siegel M, et al. State Firearm Laws and Interstate Transfer of Guns in the USA, 2006-2016. *J Urban Health.* 2018;95: 332-336.
- ¹³ Pierce GL, Braga AA, Wintemute GJ. Impact of California firearms sales laws and dealer regulations on the illegal diversion of guns. *Inj Prev.* 2015 Jun;21(3):179-84.
- ¹⁴ Rudolph KE, Stuart KE, Vernick JS, and Webster DW. Association Between Connecticut's Permit-to-Purchase Handgun Law and Homicides. *Am J Public Health.* 2015 August; 105(8): e49–e54.
- ¹⁵ Webster DW, Crifasi CK, and Vernick JS. Effects of the repeal of Missouri's Handgun Purchaser Licensing Law on Homicides. *J Urban Health.* 2014;91(2): 293-302.
- ¹⁶ Crifasi CK, Merrill-Francis M, McCourt A, et al. Association between Firearm Laws and Homicide in Urban Counties. *J Urban Health.* 2018;95(3):383-390.
- ¹⁷ Crifasi CK, Meyers JS, Vernick JS, et al. Effects of changes in permit-to-purchase handgun laws in Connecticut and Missouri on suicide rates. *Prev. Med. Preventive Medicine.* 2015;79: 43-49.
- ¹⁸ P.L. 110-80, § 102-104, 301 (2007).
- ¹⁹ Mayors Against Illegal Guns, Fatal Gaps: How Missing Records in the Federal Background Check System Put Guns in the Hands of Killers. November 2011.
- ²⁰ U.S. Government Accountability Office, Gun Control: Sharing Promising Practices and Assessing Incentives Could Better Position Justice to Assist States in Providing Records for Background Checks. Washington, D.C. July 2012.
- ²¹ U.S. Government Accountability Office, Gun Control: Sharing Promising Practices and Assessing Incentives Could Better Position Justice to Assist States in Providing Records for Background Checks. Washington, D.C. July 2012.
- ²² U.S. Government Accountability Office, Gun Control: Sharing Promising Practices and Assessing Incentives Could Better Position Justice to Assist States in Providing Records for Background Checks. Washington, D.C. July 2012.
- ²³ U.S. Government Accountability Office, Gun Control: Sharing Promising Practices and Assessing Incentives Could Better Position Justice to Assist States in Providing Records for Background Checks. Washington, D.C. July 2012.
- ²⁴ Goggins B. and Gallegos A. State Progress in Record Reporting for Firearm-Related Background Checks: Mental Health Submissions. SEARCH and the National Center for State Courts. February 2016.
- ²⁵ Bureau of Justice Statistics. Promising practices by states for improved record reporting. Available at <https://www.bjs.gov/index.cfm?ty=tp&tid=491>. Accessed August 3, 2018.

²⁶ Goggins B. and Gallegos A. State Progress in Record Reporting for Firearm-Related Background Checks: Mental Health Submissions. SEARCH and the National Center for State Courts. February 2016.

²⁷ Goggins B. and Gallegos A. State Progress in Record Reporting for Firearm-Related Background Checks: Mental Health Submissions. SEARCH and the National Center for State Courts. February 2016.

²⁸ Liu ED, Bagalman E., Chu VS, and Redhead CS. Submission of Mental Health Records to NICS and the HIPAA Privacy Rule. Congressional Research Services Report for Congress. April 15, 2013.

²⁹ 81 FR 382

³⁰ U.S. Department of Health and Human Services, HIPAA Privacy Rule and the National Instant Criminal Background Check System (NICS). Available at <https://www.hhs.gov/hipaa/for-professionals/special-topics/nics/index.html>. Accessed August 3, 2018.

³¹ 34 CFR 99.36

³² Public Law No: 115-141.

³³ Public Law No: 115-141.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(I-18)

Introduced by: Virginia, American Association of Clinical Urologists, Georgia

Subject: Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, AMA Policy H-180.956, "Physician Privileges Application – Timely Review by
2 Managed Care," states Medicare, Medicaid, and managed care organizations should
3 retroactively compensate physicians for services rendered from the date of their credentialing;
4 and

5
6 Whereas, [HB 139](#) was successfully passed by the 2018 Virginia General Assembly and signed
7 into law by Governor Northam. This allows physicians who are waiting to be credentialed by a
8 health plan to see patients and retroactively receive payments if they are ultimately
9 credentialed; and

10
11 Whereas, Physicians awaiting credentialing could be reimbursed \$1000 per day during the
12 credentialing process (*Virginia Medical News* – Spring/Summer 2018); therefore be it

13
14 RESOLVED, That our American Medical Association develop model state legislation for
15 physicians being credentialed by a health plan to treat patients and retroactively receive
16 payments if they are ultimately credentialed. (Directive to Take Action)

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

Received: 08/28/18

RELEVANT AMA POLICY

Physician Privileges Application - Timely Review by Managed Care H-180.956

Our AMA policy is that: (1) final acceptance of residents who otherwise are approved by a health plan should be contingent upon the receipt of a letter from their program director stating that their training has been satisfactorily completed; (2) health plans which require board certification should allow the completing resident to be included in their plan after showing evidence of having completed the required training and of working towards fulfilling the requirements in the time frame established by their respective Board for completion of certification; and (3) Medicare, Medicaid, and managed care organizations should (a) make final physician credentialing determinations within 45 calendar days of receipt of a completed application; (b) grant provisional credentialing pending a final credentialing decision if the credentialing process exceeds 45 calendar days; and (c) retroactively compensate physicians for services rendered from the date of their credentialing.

Res. 708, A-01 Modified Sub. Res. 701, I-01 Reaffirmed: Res. 809, I-02 Reaffirmation A-05 Reaffirmation A-15 Reaffirmed: CME Rep. 1, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(I-18)

Introduced by: Pennsylvania

Subject: Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, The opioid-overdose epidemic has had a devastating impact throughout the United
2 States and currently claims about 115 lives per day (1); and

3
4 Whereas, The Centers for Disease Control and Prevention in August 2018 reported a record
5 72,000 overdose deaths in 2017 (2); and

6
7 Whereas, Medications for opioid use disorder can facilitate recovery and prevent deaths (3);
8 and

9
10 Whereas, Great Britain, Canada and Australia have successfully made methadone available by
11 prescription, enhancing access to this valuable therapy (1); and

12
13 Whereas, Limited experience in the United States over a 10-year period has demonstrated the
14 success of such a primary care approach for treatment of opioid use disorder (1); and

15
16 Whereas, In 2001, there was a six-month randomized controlled trial that supported the success
17 of such a primary care based approach (4, 5); and

18
19 Whereas, Enhancing the opportunity for primary care practices to prescribe methadone might
20 increase the availability of such treatment in non-urban populations who lack access to
21 methadone clinics; and

22
23 Whereas, AMA Policy H-95.957 supports the concept of "...properly trained practicing
24 physicians as an extension of organized methadone maintenance programs in the management
25 of those patients whose needs for allied services are minimal..."; therefore be it

26
27 RESOLVED, That our American Medical Association identify and work to remove those
28 administrative and/or legal barriers that hamper the ability of primary care providers to prescribe
29 methadone, through all appropriate legislative and/or regulatory means possible (Directive to
30 Take Action); and be it further

31
32 RESOLVED, That our AMA, working with other federation stakeholders, identify the appropriate
33 educational tools that would support primary care physicians to provide ongoing methadone
34 treatment for appropriate patients. (Directive to Take Action)

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

Received: 09/21/18

References:

- (1) Samet JH, Botticelli MB, and Bharel M. "Perspective. Methadone in Primary Care – One Small Step for Congress, One Giant Leap for Addiction Treatment. N Eng J Med 379:7-8, 5 July2018.
- (2) <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>.
- (3) Sordo L et al. "Mortality Risk during and after opioid substitution treatment; systemic review and meta-analysis of cohort studies." BMJ 357:j1550, 2017.
- (4) Fiellin DA et al. "Methadone Maintenance in Primary Care. A Randomized Controlled Trial. JAMA 286:1724-1731, 10 Oct 2001.
- (5) Stein MD and Friedmann PD. "Editorial: Generalist Physicians and Addiction Care. From Turfing to Sharing the Turf." JAMA 286: 1764-1765, 10 Oct 2001.

RELEVANT AMA POLICY**Methadone Maintenance in Private Practice H-95.957**

Our AMA: (1) reaffirms its position that, "the use of properly trained practicing physicians as an extension of organized methadone maintenance programs in the management of those patients whose needs for allied services are minimal" (called "medical" maintenance) should be evaluated further; (2) supports the position that "medical" methadone maintenance may be an effective treatment for the subset of opioid dependent patients who have attained a degree of behavioral and social stability under standard treatment and thereby an effective measure in controlling the spread of infection with HIV and other blood-borne pathogens but further research is needed; (3) encourages additional research that includes consideration of the cost of "medical" methadone maintenance relative to the standard maintenance program (for example, the cost of additional office security and other requirements for the private office-based management of methadone patients) and relative to other methods to prevent the spread of blood-borne pathogens among intravenous drug users; (4) supports modification of federal and state laws and regulations to make newly approved anti-addiction medications available to those office-based physicians who are appropriately trained and qualified to treat opiate withdrawal and opiate dependence in accordance with documented clinical indications and consistent with sound medical practice guidelines and protocols; and (5) urges that guidelines and protocols for the use of newly approved anti-addiction medications be developed jointly by appropriate national medical specialty societies in association with relevant federal agencies and that continuing medical education courses on opiate addiction treatment be developed by these specialty societies to help designate those physicians who have the requisite training and qualifications to provide therapy within the broad context of comprehensive addiction treatment and management.

CSA Rep. 2 - I-94 Reaffirmed: CSA Rep. 12 and Append Res. 412, A-99 Reaffirmation I-00

Modified: CSAPH Rep. 1, A-10

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-18)

Introduced by: Resident and Fellow Section

Subject: Support for the Development and Distribution of HIPAA-Compliant
Communication Technologies

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law designed to protect a subset of identifiable information known as Protected Health Information (PHI) and in 2009 HIPAA was expanded and strengthened by the Health Information Technology for Economic and Clinical Health Act (HITECH Act); and

Whereas, The AMA has guidelines that expect all institutions to provide retirement benefits; and

Whereas, All technologies designed to be HIPAA-compliant must adhere to two rules: the 'Standards for Privacy of Individually Identifiable Health Information' known as the Privacy Rule, and the 'Security Standards for the Protection of Electronic Protected Health Information' known as the Security Rule¹; and

Whereas, Baseline cell phone security, text messaging and telecommunication technologies are lacking in necessary security measures to meet the standards for HIPAA-compliance^{2,3}; and

Whereas, There are an increasing number of HIPAA-compliant applications related to patient health and communication with several versions of developer's guides for HIPAA-compliance distributed online for several years; and

Whereas, Despite evidence from studies showing perceived improvement in provider communication with HIPAA-compliant text messaging applications, more than 50% of residents report routinely text messaging protected health information (PHI) in violation of HIPAA^{3,4}; therefore be it

RESOLVED, That our American Medical Association promote the development and use of Health Insurance Portability and Accountability Act of 1996 (HIPAA) -compliant technologies for text messaging, electronic mail and video conferencing. (New HOD Policy)

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

Received: 09/27/18

References:

1 <https://www.informationweek.com/healthcare/security-and-privacy/hipaa-compliance-what-every-developer-should-know/a/d-id/1297180>

2 <http://library.ahima.org/doc?oid=105342#.WbdY19hOmEc>

3 <https://link.springer.com/article/10.1007/s10916-016-0489-2>

4 <http://onlinelibrary.wiley.com/doi/10.1002/jhm.2228/full>

RELEVANT AMA POLICY

Face-to-Face Encounter Rule D-330.914

1. Our AMA will: (A) work with the Centers for Medicare & Medicaid Services (CMS) and appropriate national medical specialty societies to ensure that physicians understand the alternative means of compliance with and payment policies associated with Medicare's face-to-face encounter policies, including those required for home health, hospice and durable medical equipment; (B) work with CMS to continue to educate home health agencies on the face-to-face documentation required as part of the certification of eligibility for Medicare home health services to ensure that the certification process is streamlined and minimizes paperwork burdens for practicing physicians; and (C) continue to monitor legislative and regulatory proposals to modify Medicare's face-to-face encounter policies and work to prevent any new unfunded mandatory administrative paperwork burdens for practicing physicians.

2. Our AMA will work with CMS to enable the use of HIPAA-compliant telemedicine and video monitoring services to satisfy the face-to-face requirement in certifying eligibility for Medicare home health services. (CMS Rep. 3, I-12; Appended: Res. 120, A-14; Reaffirmed in lieu of: Res. 109, A-17)

Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging D-478.970

Our AMA will develop patient-oriented educational materials about text messaging and other non-HIPAA-compliant electronic messaging communication between physicians, patients, and members of the health care team.

Citation: Res. 227, A-16; Modified: Speakers Rep., A-18

Guidelines for Patient-Physician Electronic Mail H-478.997

New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Furthermore, before using electronic mail or other electronic communication tools, physicians should consider Health Information Portability and Accountability Act (HIPAA) and other privacy requirements, as well as related AMA policy on privacy and confidentiality, including Policies H-315.978 and H-315.989. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient's care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.

(1) For those physicians who choose to utilize e-mail for selected patient and medical practice communications, the following guidelines be adopted.

Communication Guidelines:

- (a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
- (b) Inform patient about privacy issues.
- (c) Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.
- (d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of email communications with patients.
- (e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
- (f) Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
- (g) Request that patients put their name and patient identification number in the body of the message.
- (h) Configure automatic reply to acknowledge receipt of messages.
- (i) Send a new message to inform patient of completion of request.
- (j) Request that patients use autoreply feature to acknowledge reading clinicians message.
- (k) Develop archival and retrieval mechanisms.
- (l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
- (m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
- (n) Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
- (o) Explain to patients that their messages should be concise.

(p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.

(q) Remind patients when they do not adhere to the guidelines.

(r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

Medicolegal and Administrative Guidelines:

(a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:

(b) Terms in communication guidelines (stated above).

(c) Provide instructions for when and how to convert to phone calls and office visits.

(d) Describe security mechanisms in place.

(e) Hold harmless the health care institution for information loss due to technical failures.

(f) Waive encryption requirement, if any, at patient's insistence.

(g) Describe security mechanisms in place including:

(h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.

(i) Never forwarding patient-identifiable information to a third party without the patient's express permission.

(j) Never using patient's e-mail address in a marketing scheme.

(k) Not sharing professional e-mail accounts with family members.

(l) Not using unencrypted wireless communications with patient-identifiable information.

(m) Double-checking all "To" fields prior to sending messages.

(n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.

(o) Commit policy decisions to writing and electronic form.

(2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.

(3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate.

(4) The policies and procedures for e-mail be applied to text and electronic messaging using a secure communication platform, where appropriate. (BOT Rep. 2, A-00; Modified: CMS Rep. 4, A-01; Modified: BOT Rep. 24, A-02; Reaffirmed: CMS Rep. 4, A-12; Modified: BOT Rep. 11, A-17)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(I-18)

Introduced by: Resident and Fellow Section

Subject: Restriction on IMG Moonlighting

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, The Association of American Medical Colleges predicts a physician shortage of more than 100,000 doctors by the year 2030¹; and

Whereas, International Medical Graduates (IMGs) are more likely to practice in primary care specialties than US medical graduates²; and

Whereas, Foreign-born IMGs were more likely to practice in rural underserved areas than US born IMGs²; and

Whereas, The Educational Commission for Foreign Medical Graduates (ECFMG) sponsors approximately 10,000 J-1 visas annually; and

Whereas, The ECFMG prohibits physicians with a J-1 visa from moonlighting based on the US Code of Federal Regulations 22CFR62.16³, and subsequently prohibits physicians with J-1 visas privileges to bill for services rendered; and

Whereas, Providing physicians with a J-1 visa billing privileges and the ability to moonlight may improve the access to care in certain areas; therefore be it

RESOLVED, That our American Medical Association advocate for changes to federal legislation allowing physicians with a J-1 visa in fellowship training programs the ability to moonlight. (New HOD Policy)

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

Received: 09/27/18

RELEVANT AMA POLICY

Employment of Non-Certified IMGs H-255.970

Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure; and (2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs.

Citation: (Res. 309, A-03; Reaffirmed: CME Rep. 2, A-13)

References:

¹ Research Shows Shortage of More than 100,000 Doctors by 2030. Available at: <https://news.aamc.org/medical-education/article/new-aamc-research-reaffirms-looming-physician-short/>.

² International Medical Graduates and The Primary Care Workforce For Rural Underserved Areas. Available at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.22.2.255>.

³ Employment Outside of the Approved Training Program ("Moonlighting"). Available at <https://www.ecfm.org/evsp/evspemot.pdf>.

MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(I-18)

Introduced by: International Medical Graduates Section

Subject: Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, Our AMA has supported legalization of the Deferred Action for Early Childhood Arrival (DACA) children brought to this country illegally by their parents; and

Whereas, Our AMA has supported reducing the backlog of granting of green cards for permanent residency which sometimes has been delayed for several years. This delay leads to their children turning 21 years of age and thus becoming illegal; and

Whereas, There are thousands of children who arrived in this country with their parents legally, however once they turn 21 years of age they automatically become illegal. They are then called DALCA (Deferred Action for Legal Childhood Arrival); and

Whereas, There are 80,000-100,000 children that fall into this category; and

Whereas, Many of these DALCA children are in medical schools or have already graduated from U.S. medical schools, but are subject to deportation because they are considered illegals. Many of these DALCA children have matched in residency programs but have been held back due to their lack of proper legal status; and

Whereas, There is bipartisan support in Congress for these children which has not garnered media headlines; therefore be it

RESOLVED, That our American Medical Association support legalization of the Deferred Action for Legal Childhood Arrival (DALCA) (New HOD Policy); and be it further

RESOLVED, That our AMA work with the appropriate agencies to allow DALCA children to start and finish medical school and/or residency training until these DALCA children have officially become legal. (Directive to Take Action)

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

Received: 09/28/18

References:

"Consideration of Deferred Action for Childhood Arrivals (DALCA)"

"Deferred Action for Childhood Arrivals: Response to January 2018 Preliminary Injunction"

<https://www.uscis.gov/humanitarian/deferred-action-childhood-arrivals-response-january-2018-preliminary-injunction>

"Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children Memorandum," June 15, 2012, <https://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf>

RELEVANT AMA POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

(Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18)

Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986

1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.
2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.

(Res. 305, A-15; Appended: Late Res. 1001, I-16)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-18)

Introduced by: Florida

Subject: Repealing Potential Penalties Associated with MIPS

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Reporting data under the Merit-based Incentive Payment System (MIPS) increases
2 the administrative burden on physicians and takes time away from patient care; and
3

4 Whereas, The maximum potential payment penalty under MIPS will incrementally increase to
5 9%; and
6

7 Whereas, Many physician practices that serve Medicare beneficiaries cannot sustain additional
8 reductions in their Medicare payments; and
9

10 Whereas, Small and medium-sized physician practices are likely to be disproportionately
11 impacted by penalties under MIPS; and
12

13 Whereas, Participation in pay-for-performance programs should not be compulsory; therefore
14 be it
15

16 RESOLVED, That our American Medical Association advocate to repeal all potential penalties
17 associated with the MIPS program. (Directive to Take Action)

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

Received: 09/27/18

RELEVANT AMA POLICY

Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program D-395.998

1. Our AMA will oppose the replacement of the Merit-Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently defined.
2. Our AMA will study the criticisms of the Merit-Based Incentive Payment System (MIPS) program as offered by proponents of the VVP to determine where improvement in the MIPS program needs to be made.
3. Our AMA will continue its advocacy efforts to improve the MIPS program, specifically requesting: (a) true EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures; (b) safe harbor protections for entities providing clinical data for use in the MIPS program; (c) continued infrastructure support for smaller practices that find participation particularly burdensome; (d) adequate recognition of and adjustments for socioeconomic and demographic factors that contribute to variation in patient outcomes as well as geographic variation; and (e) limiting public reporting of physician performance to those measures used for scoring in the MIPS program.
4. Our AMA will determine if population measures are appropriate and fair for measuring physician performance.

Citation: Res. 247, A-18

Reducing MIPS Reporting Burden D-395.999

Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physicians choosing) within the calendar year.

Citation: Res. 236, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(I-18)

Introduced by: Medical Student Section

Subject: Defense of Affirmative Action

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Affirmative action is a race-conscious recruitment policy designed to equalize access
2 to jobs and professions such as medicine and is based on the premise that relief from illegal
3 racial discrimination is not enough to remove the burden of second-class citizenship from
4 underrepresented minority groups;¹ and

5
6 Whereas, Affirmative action has been identified as a potent method for ameliorating racial
7 disparities and increasing diversity in public universities;^{2,3} and

8
9 Whereas, University enrollment is directly correlated with attaining higher social status;⁴ and

10
11 Whereas, Diversity in the student body fosters a greater understanding of patient populations
12 and preparation for medical care to an increasingly multicultural society;^{5,6} and

13
14 Whereas, Underrepresented minority physicians are more likely to practice in underserved
15 areas and tend to serve populations with higher percentages of medically indigent patients;⁷⁻⁹
16 and

17
18 Whereas, Affirmative action has shown to increase medical practice in underserved areas with
19 minority populations and providing better healthcare for various communities;¹⁰ and

20
21 Whereas, Several states that have instituted bans on affirmative action have experienced
22 subsequent decreases in college enrollment by minority students, completion of STEM degrees
23 by minority students, and representation of minority students among matriculating medical
24 school students;^{2,3,11,12} and

25
26 Whereas, In 1978, 2003, and 2016 the supreme court upheld affirmative action in the cases of
27 *Regents of the University of California v. Bakke*, *Grutter v. Bollinger*, and *Fisher v. The*
28 *University of Texas at Austin*, respectively, allowing race to be one of several factors in college
29 admission policy;¹³⁻¹⁵ and

30
31 Whereas, Although AMA policy establishes a significant precedent to support undergraduate
32 education as a means to produce medical school matriculants (H-60.917, H-350.979,
33 H-200.985), existing policy falls short of addressing the necessity of affirmative action as
34 mechanism for equality at the undergraduate level, which is necessary to bolster the pool of
35 minority students able to apply to a medical program; and

36
37 Whereas, The Department of Justice has announced the intent to investigate and potentially
38 sue institutions utilizing affirmative action, threatening the principles of racial equality in
39 education that our AMA supports;¹⁶ therefore be it

- 1 RESOLVED, That our American Medical Association oppose legislation that would undermine
 2 institutions' ability to properly employ affirmative action to promote a diverse student population.
 3 (New HOD Policy)

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

Received: 09/28/18

References:

1. Curtis, JL. Affirmative action in U.S. medical schools. *Affirmative Action in Medicine: Improving Health Care for Everyone*. Ann Arbor, MI: University of Michigan Press; 2003:13-34.
2. Porter, M, Clausen, E. *Fisher* ruling requires buy-in, assessment of diversity, affirmative action. *Enrollment Management Report*. 2016;20(10):1-8.
3. Dickson, LM. Does Ending Affirmative Action in College Admissions Lower the Percent of Minority Students Applying to College? *Economics of Education Review*. 2006;25(1):109-19.
4. Hinrichs, P. The Effects of Affirmative Action Bans on College Enrollment, Educational Attainment, and the Demographic Composition of Universities. *Review of Economics and Statistics*. 2012;94(3):712-722.
5. Lakhan SE. Diversification of U.S. medical schools via affirmative action implementation. *BMC Medical Education*. 2003;3(1).
6. Saha, S, Guiton, G, Wimmers, PF. *et al*. Student Body Racial and Ethnic Composition and Diversity-Related Outcomes in US Medical Schools. *JAMA*. 2008;300(10):1135-1145.
7. Kington, R, Tisnado, D, Carlisle, DM. Increasing racial and ethnic diversity among physicians: an intervention to address health disparities? *The Right Thing To Do, The Smart Thing To Do: Enhancing Diversity in the Health Professions*. Washington, DC: The National Academies Press; 2001:57-90.
8. Walker, KO, Moreno, G, Grumbach, K. The Association Among Specialty, Race, Ethnicity, and Practice Location Among California Physicians in Diverse Specialties. *J Natl Med Assoc*. 2012;104(0):46-52.
9. Marrast, LM, Zallman, L, Woolhandler, S. *et al*. Minority Physicians' Role in the Care of Underserved Patients: Diversifying the Physician Workforce May Be Key in Addressing Health Disparities. *JAMA Intern Med*. 2014;174(2):289-291.
10. Lakhan SE. Diversification of U.S. medical schools via affirmative action implementation. *BMC Medical Education*. 2003;3(1).
11. Hill, AJ. State Affirmative Action Bans and STEM Degree Completions. *Economics of Education Review*. 2017;57:31-40.
12. Garces, LM, Mickey-Pabello, D. Racial Diversity in the Medical Profession: The Impact of Affirmative Action Bans on Underrepresented Student of Color Matriculation in Medical Schools. *J Higher Educ*. 2015 Mar-Apr;86(2):264-294.
13. *Regents of University of California v. Bakke* 438 U.S. 265 (1978).
14. Gratz v. Bollinger; Grutter v. Bollinger. The Center for Individual Rights. <https://www.cir-usa.org/cases/gratz-v-bollinger-grutter-v-bollinger>. Accessed August 25, 2017.
15. *Fisher v. University of Texas at Austin et al*. 579 U.S. ____ (2016).
16. Savage, A. Justice Dept. to Take On Affirmative Action in College Admissions. *New York Times*. August 1st, 2017

RELEVANT AMA POLICY

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917

Our AMA: (1) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (2) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (3) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.

Citation: Res. 910, I-16

Equal Opportunity H-65.968

Our AMA: (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; (2) affirms the concept that equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender; (3) affirms the concept of equal rights for men and women; and (4) endorses the principle of equal opportunity of employment and practice in the medical field.

Citation: (CCB/CLRPD Rep. 4, A-13)

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.

- (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
- (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
- (4) Increasing the supply of minority health professionals.
- (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
- (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
- (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
- (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(I-18)

Introduced by: Nebraska, Georgia, West Virginia, Florida, Mississippi, South Carolina,
Arkansas, Oklahoma, New Jersey, Tennessee

Subject: Increasing Access to Broadband Internet to Reduce Health Disparities

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Our AMA recognizes that social determinants of health, including circumstances of
2 early life, social gradient, unemployment, and social exclusion, should be taught in medical
3 school (H-295.874) and built in to payment models (H-160.896); and
4

5 Whereas, Residents of rural areas in the United States tend to be older and sicker than their
6 urban counterparts with higher rates of poverty, less access to healthcare, and higher likelihood
7 of dying from 5 leading causes of death when compared to their urban counterparts; and
8

9 Whereas, 23 million Americans live in areas that do not have broadband internet access; and
10

11 Whereas, Broadband internet provides access to resources not only for health care but also for
12 economic growth and job opportunities, educational opportunities, and government services;
13 and
14

15 Whereas, Our AMA has a broad swath of policies which encourage the use of, and pay for,
16 telemedicine, which requires broadband internet; and
17

18 Whereas, The Federal Communications Commission Connect2Health Task Force is currently
19 exploring the intersections of health and technology in rural areas; therefore be it
20

21 RESOLVED, That our American Medical Association advocate for the expansion of broadband
22 connectivity to all rural areas of the United States. (New HOD Policy)

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

Received: 09/28/18

RELEVANT AMA POLICY

Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874

Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.

Citation: CME Rep. 11, A-06; Reaffirmation A-11; Modified in lieu of Res. 908, I-14; Reaffirmed in lieu of Res. 306, A-15; Reaffirmed: BOT Rep. 39, A-18

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896

Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.

Citation: BOT Rep. 39, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(I-18)

Introduced by: Women Physicians Section

Subject: Sexual Assault Education and Prevention in Public Schools

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Although the AMA has existing policy on the education and prevention of sexual
2 assault on college campuses, many adolescents have become victims of sexual assault and
3 AMA policy does not explicitly address this topic for this age group; and
4

5 Whereas, More than forty-two percent (42.2%) of forced sexual violence victims are assaulted
6 before they are 18 years old¹; and
7

8 Whereas, More than eleven percent (11.3%) of female high school students and 3.5% of male
9 high school students responding to the 2017 National Youth Risk Behavior Survey reported
10 victimization by forced sex²; and
11

12 Whereas, The 2017 National Youth Risk Behavior Survey also notes the incidence of forced sex
13 has failed to improve over the last decade among high school students²; and
14

15 Whereas, A significantly higher percentage of female students (10.7%) reported this sexual
16 dating violence in the past year compared to male students (2.8%)²; and
17

18 Whereas, Both forced sex and sexual dating violence disproportionately affects sexual
19 minorities in high school with 21.9% of lesbian, gay, or bisexual youth reporting forced sex
20 (compared to 5.4% of heterosexual youth)²; and
21

22 Whereas, At least two states (California and Missouri) require education of high school students
23 regarding consent as part of a mandate to teach about healthy relationships, and several others
24 have recently considered such legislation as the majority of U.S. teens may graduate high
25 school without any formal instruction on consent⁴⁻⁶; therefore be it
26

27 RESOLVED, That our American Medical Association support state legislation mandating that
28 public middle and high school health education programs include age appropriate information
29 on sexual assault education and prevention, including but not limited to topics of consent and
30 sexual bullying. (Directive to Take Action)

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

Received: 09/28/18

References:

1. Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens MR. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2011.
2. Youth Risk Behavior Surveillance — United States, 2017. Available at <https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2017/ss6708.pdf>.
3. Culture of Silence: How a lack of consent education harms high school students. Available at <https://www.sjsreview.com/9257/news/how-a-lack-of-consent-education-harms-high-school-students/>.
4. An Act to amend and reenact § 22.1-207.1:1 of the Code of Virginia, relating to high school family life education curricula; elements of effective and evidence-based programs on consent. Available at <http://lis.virginia.gov/cgi-bin/legp604.exe?171+ful+CHAP0299>.
5. Teaching Consent: Could Oklahoma Lead a New Wave in Sex Education? Available at <https://www.rollingstone.com/politics/politics-news/teaching-consent-could-oklahoma-lead-a-new-wave-in-sex-education-629220/>.
6. Governor approves bills on marriage age, teaching of consent in schools. Available at <https://krcgtv.com/news/local/governor-approves-bills-on-marriage-age-teaching-of-consent-in-schools>.

RELEVANT AMA POLICY**Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968**

- (1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
- (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
- (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
- (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
- (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
- (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
- (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted

infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;

(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and

(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

Citation: CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16; Appended: Res. 401, A-16; Appended: Res. 414, A-18; Appended: Res. 428, A-18

Addressing Sexual Assault on College Campuses H-515.956

Our AMA: (1) supports universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting; (2) will work with relevant stakeholders to address the issues of rape, sexual abuse, and physical abuse on college campuses; and (2) will strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses.

Citation: Res. 402, A-16; Appended: Res. 424, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(I-18)

Introduced by: District of Columbia

Subject: Forced Organ Harvesting for Transplantation

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Ethical guidelines for transplantation are set forth by our AMA, the World Medical
2 Association and the World Health Organization; the medical profession has the responsibility to
3 protect the rights and interests of patients who need and seek transplant surgery, as well as to
4 protect the rights and interests of organ donors whose organs may have been procured in
5 unethical manner; and

6
7 Whereas, China is second only to the United States as the country that performs the largest
8 number of transplants and thus has a particular responsibility to act ethically and transparently
9 regarding organ transplants; and

10
11 Whereas, Systematic, state-sanctioned organ harvesting from executed prisoners and prisoners
12 of conscience in China has occurred with the knowledge of the Chinese government; and there
13 are also reports about forced organ harvesting from Uighurs, House Christians, Tibetans and
14 Falun Gong practitioners; and

15
16 Whereas, The U.S. Congress passed House Resolution 343 in 2016, calling for an end to
17 forced organ harvesting from Falun Gong prisoners of conscience in China; and the European
18 Parliament also passed Written Declaration 48 in 2016, calling for investigations and an end to
19 forced organ harvesting from Falun Gong prisoners of conscience in China; and

20
21 Whereas, Doctors Against Forced Organ Harvesting (DAFOH), a medical NGO that was
22 nominated twice for a Nobel Peace Prize, collected over 3 million signatures for a petition to the
23 U.N. High Commissioner for Human Rights, calling for an end to forced organ harvesting in
24 China; and

25
26 Whereas, Chinese transplant numbers have increased dramatically and transplant tourism has
27 become a lucrative source of income in China, leading to a rapid expansion of the transplant
28 infrastructure in China; and China has declared the Hainan Islands to be a special economic
29 zone for medical tourism; therefore be it

30
31 RESOLVED, That our American Medical Association reaffirm Ethical Opinion E-6.1.1,
32 "Transplantation of Organs from Living Donors," and believes that transplant surgeons,
33 especially those who come to the United States for training in transplant surgery, must agree to
34 these guidelines, and that American medical and hospital institutions not be complicit in any
35 ethical violations or conflicts of interest (New HOD Policy); and be it further

1 RESOLVED, That our AMA representatives to the World Medical Association request an
 2 independent, interdisciplinary (not restricted to transplant surgeons), transparent investigation
 3 into the Chinese practices of organ transplantation including (but not limited to): the source of
 4 the organs as well as the guidelines followed; and to report back on these issues as well as the
 5 status of Prisoners of Conscience as sources of transplantable organs (Directive to Take
 6 Action); and be it further

7
 8 RESOLVED, That our AMA call upon the U.S. Government to protect the large number of
 9 transplant tourists by implementing legislation to regulate the evolving, ethical challenges by
 10 initiating a Reciprocal Transplant Transparency Act which would blacklist countries that do not
 11 meet the same transparency and ethical standards practiced in the U.S. (such as the public
 12 listing of annual transplant numbers by every transplant center to permit scrutiny). (Directive to
 13 Take Action)

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

Received: 09/27/18

RELEVANT AMA POLICY

E-6.1.1 Transplantation of Organs from Living Donors

Donation of nonvital organs and tissue from living donors can increase the supply of organs available for transplantation, to the benefit of patients with end-stage organ failure. Enabling individuals to donate nonvital organs is in keeping with the goals of treating illness and relieving suffering so long as the benefits to both donor and recipient outweigh the risks to both.

Living donors expose themselves to harm to benefit others; novel variants of living organ donation call for special safeguards for both donors and recipients.

Physicians who participate in donation of nonvital organs and tissues by a living individual should:

- (a) Ensure that the prospective donor is assigned an advocacy team, including a physician, dedicated to protecting the donors well-being.
- (b) Avoid conflicts of interest by ensuring that the health care team treating the prospective donor is as independent as possible from the health care team treating the prospective transplant recipient.
- (c) Carefully evaluate prospective donors to identify serious risks to the individual's life or health, including psychosocial factors that would disqualify the individual from donating; address the individual's specific needs; and explore the individual's motivations to donate.
- (d) Secure agreement from all parties to the prospective donation in advance so that, should the donor withdraw, his or her reasons for doing so will be kept confidential.
- (e) Determine that the prospective living donor has decision-making capacity and adequately understands the implications of donating a nonvital organ, and that the decision to donate is voluntary.
- (f) In general, decline proposed living organ donations from unemancipated minors or legally incompetent adults, who are not able to understand the implications of a living donation or give voluntary consent to donation.
- (g) In exceptional circumstances, enable donation of a nonvital organ or tissue from a minor who has substantial decision-making capacity when:
 - (i) the minor agrees to the donation;
 - (ii) the minor's legal guardians consent to the donation;
 - (iii) the intended recipient is someone to whom the minor has an emotional connection.
- (h) Seek advice from another adult trusted by the prospective minor donor when circumstances warrant, or from an independent body such as an ethics committee, pastoral service, or other institutional resource.
- (i) Inform the prospective donor:

- (i) about the donation procedure and possible risks and complications for the donor;
- (ii) about the possible risks and complications for the transplant recipient;
- (iii) about the nature of the commitment the donor is making and the implications for other parties;
- (iv) that the prospective donor may withdraw at any time before undergoing the intervention to remove the organ or collect tissue, whether the context is paired, domino, or chain donation; and
- (v) that if the donor withdraws, the health care team will report simply that the individual was not a suitable candidate for donation.
- (j) Obtain the prospective donor's separate consent for donation and for the specific intervention(s) to remove the organ or collect tissue.
- (k) Ensure that living donors do not receive payment of any kind for any of their solid organs. Donors should be compensated fairly for the expenses of travel, lodging, meals, lost wages, and medical care associated with the donation only.
- (l) Permit living donors to designate a recipient, whether related to the donor or not.
- (m) Decline to facilitate a living donation to a known recipient if the transplantation cannot reasonably be expected to yield the intended clinical benefit or achieve agreed on goals for the intended recipient.
- (n) Permit living donors to designate a stranger as the intended recipient if doing so produces a net gain in the organ pool without unreasonably disadvantaging others on the waiting list. Variations on donation to a stranger include:
 - (i) prospective donors who respond to public solicitations for organs or who wish to participate in a paired donation ("organ swap," as when donor-recipient pairs Y and Z with incompatible blood types are recombined to make compatible pairs: donor-Y with recipient-Z and donor-Z with recipient-Y);
 - (ii) domino paired donation;
 - (iii) nonsimultaneous extended altruistic donation ("chain donation").
- (o) When the living donor does not designate a recipient, allocate organs according to the algorithm that governs the distribution of deceased donor organs.
- (p) Protect the privacy and confidentiality of donors and recipients, which may be difficult in novel donation arrangements that involve many patients and in which donation-transplant cycles may be extended over time (as in domino or chain donation).
- (q) Monitor prospective donors and recipients in proposed nontraditional donation arrangements for signs of psychological distress during screening and after the transplant is complete.
- (r) Support the development and maintenance of a national database of living donor outcomes to support better understanding of associated harms and benefits and enhance the safety of living donation.

[AMA Principles of Medical Ethics: I,V,VII,VIII](#)

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(I-18)

Introduced by: Heart Rhythm Society
American College of Cardiology
American Society for Echocardiography
Society for Cardiovascular Angiography and Interventions

Subject: Eliminating Barriers to Automated External Defibrillator Use

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Sudden cardiac arrest (SCA) affects over 40,000 people in the public environment
2 annually in the United States and early and prompt bystander automated external defibrillator
3 (AED) use has been shown to be key for survival from SCA¹; and
4

5 Whereas, Current research have shown that AEDs are used in less than 5% of public SCA
6 events²; and
7

8 Whereas, Despite efforts to establish AED availability in schools, workplaces and public spaces
9 (as supported by AMA Policy H-130.938), studies have shown that the majority of the public
10 either cannot identify an AED or are not aware of where AEDs are located²; and
11

12 Whereas, Due to the combination of inadequate public education about AED use, presence of
13 labeling on AEDs that state "Trained Responders Only", and variations in state legislation with
14 respect to legal protection for "Good Samaritans" who use AEDs, most laypersons are not
15 aware that AEDs can be used by non-medical professionals³; therefore be it
16

17 RESOLVED, That our American Medical Association update its policy on cardiopulmonary
18 resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the
19 importance of AED use and public awareness of AED locations, by using solutions such as
20 integrating AED sites into widely accessible mobile maps and applications (New HOD Policy);
21 and be it further
22

23 RESOLVED That our AMA urge AED vendors to remove labeling from AED stations that
24 stipulate that only trained medical professionals can use the defibrillators (Directive to Take
25 Action); and be it further
26

27 RESOLVED That our AMA support consistent and uniform legislation across states for the legal
28 protection of untrained personnel who use AEDs in the course of attempting to aid a sudden
29 cardiac arrest victim. (Directive to Take Action)

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

Received: 09/26/18

REFERENCES

- ¹. Roger VL, Go AS, Lloyd-Jones DM, Benjamin EJ, Berry JD, Borden WB, Bravata DM, Dai S, Ford ES, Fox CS, Fullerton HJ, Gillespie C, Hailpern SM, Heit JA, Howard VJ, Kissela BM, Kittner SJ, Lackland DT, Lichtman JH, Lisabeth LD, Makuc DM, Marcus GM, Marelli A, Matchar DB, Moy CS, Mozaffarian D, Mussolino ME, Nichol G, Paynter NP, Soliman EZ, Sorlie PD, Sotoodehnia N, Turan TN, Virani SS, Wong ND, Woo D, Turner MB, American Heart Association Statistics C and Stroke Statistics S. Heart disease and stroke statistics--2012 update: a report from the American Heart Association. *Circulation*. 2012;125:e2-e220.
- ². Schober P, van Dehn FB, Bierens JJ, Loer SA and Schwarte LA. Public access defibrillation: time to access the public. *Ann Emerg Med*. 2011;58:240-7.
- ³. Gonzalez M, Leary M, Blewer AL, Cinousis M, Sheak K, Ward M, Merchant RM, Becker LB and Abella BS. Public knowledge of automatic external defibrillators in a large U.S. urban community. *Resuscitation*. 2015;92:101-6.

RELEVANT AMA POLICY**Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938**

Our AMA: (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation; (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs; (3) encourages the American public to become trained in CPR and the use of automated external defibrillators; (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held; (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events; (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices; (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel; (8) supports the development and use of universal connectivity for all defibrillators; and (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use.

Citation: (CCB/CLRPD Rep. 3, A-14; Appended: Res. 211, I-14; Modified: Res. 919, I-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(I-18)

Introduced by: Medical Student Section

Subject: Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, 1,981 people were injured and 590 people were killed during mass shootings in 2017;¹ and

Whereas, Research suggests that an incident of a mass shooting increases the probability of another mass shooting in the immediate future, with the increased probability lasting for an average of thirteen days and abetting an average of 0.30 new events, suggesting a contagion effect;^{2,3} and

Whereas, The contagion effect was previously demonstrated in suicides in the mid-1990s and led to the development of media coverage guidelines by the CDC and more recently by the WHO;^{4,5,6} and

Whereas, Multiple media organizations, including Associated Press Managing Editors and the National Press Photographers Association, have contributed to the publication and adherence of reporting guidelines for suicide that largely reflect the CDC's published guidelines;^{7,8} and

Whereas, Appropriate media coverage of suicide may lead to a reduction in suicide rates, an effect known as the Papageno effect;⁹⁻¹² and

Whereas, Analysis of media coverage of mass shootings followed by copycat incidents of mass shootings indicate a media contagion effect;^{2,3,9,13} therefore be it

RESOLVED, That our American Medical Association encourage the Centers for Disease Control and Prevention, the National Institute of Mental Health, the Associated Press Managing Editors, the National Press Photographers Association, and other relevant organizations to develop guidelines for media coverage of mass shootings in a manner that is unlikely to provoke additional incidents. (New HOD Policy)

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

Received: 09/28/18

References:

1. U.S. Mass Shootings, 2017. (n.d.). Retrieved April 10, 2018, from <https://massshootingtracker.org/data/2017>
2. Towers, S., Gomez-Lievano, A., & Khan, M. (2015). Contagion in mass killings and school shootings. *PLoS One*, 10(7). doi:10.1371/journal.pone.0117259
3. Garcia-Bernardo, J., Qi, H., Shultz, J. M., Cohen, A. M., Johnson, N. F., & Dodds, P. S. (2015). Social media affects the timing, location, and severity of school shootings. *ArXiv*. doi:arXiv:1506.06305
4. Suicide Contagion and the Reporting of Suicide: Recommendations from a National Workshop. (1994, April 22). Retrieved March 29, 2018, from <https://www.cdc.gov/mmwr/preview/mmwrhtml/00031539.htm>
5. Gould, D. L., MS. (1989). Contagion as a risk factor for youth suicide. In: Alcohol, Drug Abuse, and Mental Health Administration. Report of the Secretary's Task Force on Youth Suicide. Vol 2. Risk factors for youth suicide. Washington, DC: US Department of Health and Human Services, Public Health Service. Retrieved March 28, 2018, from <https://www.cdc.gov/mmwr/preview/mmwrhtml/00031539.htm>. DHHS publication no. (ADM)89-1622
6. Preventing suicide: A resource for media professionals. (2008). Retrieved April 10, 2018, from http://www.who.int/mental_health/prevention/suicide/resource_media.pdf
7. Recommendations for Reporting on Suicide. (n.d.). Retrieved March 29, 2018, from <http://reportingonsuicide.org/recommendations/>
8. Australian Communications and Media Authority. (2013). Commercial TV Industry Code of Practice. Retrieved from [http://www.acma.gov.au/~media/Broadcasting Investigations/Regulation/pdf/Commercial Television Industry Code of Practice 2010.pdf](http://www.acma.gov.au/~media/Broadcasting%20Investigations/Regulation/pdf/Commercial%20Television%20Industry%20Code%20of%20Practice%202010.pdf)
9. Johnston, J., & Joy, A. (2016). Mass Shootings and the Media Contagion Effect. APA Conference August 2016. doi:10.1037/e510392016-0012"Media Contagion" Is Factor in Mass Shootings, Study Says. (2016, August 4). Retrieved March 29, 2018, from <http://www.apa.org/news/press/releases/2016/08/media-contagion.aspx>
10. Till, B., Tran, U. S., Voracek, M., & Niederkrotenthaler, T. (2017). Beneficial and harmful effects of educative suicide prevention websites: Randomised controlled trial exploring Papageno v. Werther effects. *British Journal of Psychiatry*, 211(02), 109-115. doi:10.1192/bjp.bp.115.177394
11. Niederkrotenthaler, T., Voracek, M., Herberth, A., Till, B., Strauss, M., Etzersdorfer, E., . . . Sonneck, G. (2010). Role of media reports in completed and prevented suicide: Werther v. Papageno effects. *British Journal of Psychiatry*, 197(03), 234-243. doi:10.1192/bjp.bp.109.074633
12. Cheng, Q., Chen, F., Lee, E. S., & Yip, P. S. (2018). The role of media in preventing student suicides: A Hong Kong experience. *Journal of Affective Disorders*, 227, 643-648. doi:10.1016/j.jad.2017.11.007
13. Meindl, J. N., & Ivy, J. W. (2017). Mass Shootings: The Role of the Media in Promoting Generalized Imitation. *American Journal of Public Health*, 107(3), 368-370. doi:10.2105/ajph.2016.303611

RELEVANT AMA POLICY

Mass Media Violence and Film Ratings H-515.974

Redressing Shortcomings in the Current System: The AMA: (1) will speak out against the excessive portrayal of violence in the news and entertainment media, including newscasts, movies, videos, computer games, music and print outlets, and encourage the depiction of the medical, social and legal consequences of violence by the media;

(2) advises physicians to counsel parents about the known effects of media violence on children's behavior and encouraging them to reduce the amount of violent programming viewed by their children;

(3) monitors changes in the current ratings system and working through state medical societies to inform physicians and their patients about these changes; and

(4) supports all other appropriate measures to address and reduce television, cable television, and motion picture violence.

Citation: BOT Rep. 18, A-94; Modified: Res. 417, I-95; Appended: Sub. Res. 419, A-98;
Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmation: A-13 ; Reaffirmation: A-18

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;

(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and

(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

Citation: Res. 1011, A-16; Reaffirmation: A-18

Physicians and the Public Health Issues of Gun Safety D-145.997

Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

Citation: (Res. 410, A-13)

Epidemiology of Firearm Injuries D-145.999

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms.

Citation: Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13; Reaffirmation: A-18

Firearm Related Injury and Death: Adopt a Call to Action H-145.973

Our AMA endorses the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.

Citation: Res. 214, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(I-18)

Introduced by: Medical Student Section

Subject: Increasing Firearm Safety to Prevent Accidental Child Deaths

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, 1.7 million children live in homes with unlocked, loaded firearms and 1 in 3 homes with children have one or more firearms;¹ and

Whereas, A study found that 50.2% of children were often in homes that contained firearms, including their own and other homes;² and

Whereas, Studies on unintentional shootings have found that from 2005 to 2014, roughly 20,000 American minors were killed or seriously injured in accidental shootings; the majority of those killed in these tragic accidents were aged 12 or younger;^{3,4} and

Whereas, Studies have found that in firearm-owning households with children, there exists a significant reporting gap between those who actually own the firearm and those who do not regarding the type, number, and storage status of firearms in the home;^{5,6} and

Whereas, In some cases, the parent who does not own the firearm may be unaware that there is a firearm in the house at all;^{5,6} and

Whereas, The American Academy of Pediatrics (AAP) recommends that pediatricians include questions about the presence and availability of firearms in their patient history and urge parents owning firearms to take action to prevent children from gaining access to those firearms;⁷ and

Whereas, AMA Policy H-145.990 encourages physicians to educate patients on the dangers of firearms to children, but H-145.990 does not address the issue of disparities in reporting firearms between adults in households;⁸ and

Whereas, Various firearm product safety features exist that have proven to reduce youth firearm injuries, such as grip safeties, magazine disconnect devices, and personalization of firearms;⁹ and

Whereas, A magazine disconnect device physically prevents a firearm from being discharged if the magazine has been taken out, even if the chamber still has a round in it;¹⁰ and

Whereas, The U.S. General Accounting Office estimates 31% of accidental firearm deaths might be prevented by the addition of a child-proof safety lock (8%) and a loading indicator (23%), which indicates whether a firearm is loaded and if it still contains rounds in the chamber;⁹ and

Whereas, The AAP's Council on Injury, Violence, and Poison Prevention recommends safe storage and firearm safety features (i.e. trigger locks, lock boxes, gun safes) and supports the funding of research related to the prevention of firearm injury;⁷ and

Whereas, The California Department of Justice declared any center-fire semi-automatic pistol to be an "unsafe handgun" if it does not have a chamber load indicator or a magazine disconnect mechanism;¹¹ and

Whereas, Research spending on firearm injuries conducted by the CDC fell by 96% from 1996 to 2012;¹² and

Whereas, A study concluded that between 2004 and 2015, research on national firearm violence was significantly underfunded and understudied relative to other leading causes of death, receiving less than 1.6% of the \$1.4 billion researchers predicted should be allocated to study a public health issue with a similar number of deaths annually;¹³ and

Whereas, Existing AMA policy H-145.979 supports legislation that holds firearm owners legally responsible for injury or death caused by a child gaining access to a firearm;¹⁴ and

Whereas, Child Access Prevention (CAP) laws, which encourage firearm owners to be conscious of how they store their firearms, may be more preventive than AMA policy because they range from strict laws that hold gun owners criminally liable when a child could likely gain access to their gun to more lenient forms that only hold gun owners criminally liable if a child actually obtains or uses the gun;¹⁵ and

Whereas, CAP laws are currently active in twenty-seven states as well as Washington D.C.;¹⁶ and

Whereas, Most states that enacted CAP laws experienced greater declines in the rate of unintentional firearm deaths for children ages 0 to 14 compared with states not enacting the laws;¹⁷ and

Whereas, Only states with felony prosecution for violation of CAP laws had statistically significant declines in unintentional firearm deaths when adjusted for firearm prevalence;¹⁷ and

Whereas, when CAP laws were implemented, self-inflicted firearm injuries fell by 64% for youth ages 18 and under, but did not decrease for adults based on data from the Agency for Healthcare Research and Quality's Nationwide Inpatient Sample (NIS);¹⁸ therefore be it

RESOLVED, That our American Medical Association advocate for enactment of Child Access Prevention laws in all 50 states or as federal law. (New HOD Policy)

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

Date Received: 09/24/18

REFERENCES:

1. Children's Hospital of Philadelphia Research Institute: Center for Injury Research and Prevention. (2017) "Gun Violence: Facts and Statistics" Available at: <https://injury.research.chop.edu/violence-prevention-initiative/types-violence-involving-youth/gun-violence/gun-violence-facts-and#.WmNfJJM-d-V>
2. Garbutt, Jane, et al. (2016) "What are parents willing to discuss with their pediatrician about firearm safety? A parental survey" 179, pp 166-171 Available at: [http://www.jpeds.com/article/S0022-3476\(16\)30686-2/fulltext](http://www.jpeds.com/article/S0022-3476(16)30686-2/fulltext)
3. Centers for Disease Control and Prevention. (2016) "Injury Reports, National, Regional and State, 1981 – 2016: Data and Statistics" Available at: http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html and <http://webappa.cdc.gov/sasweb/ncipc/nfirates2001.html>

4. Centers for Disease Control and Prevention. (2014) "Nonfatal Injury Reports, 2001 - 2014: Data and Statistics" Available at: <http://webappa.cdc.gov/sasweb/ncipc/nfirates2001.html>
5. Azrael, D., et al. (2000) "Are household firearms stored safely? It depends on whom you ask." Pediatrics, 106(3), pp.e31-e31. Available at: <http://pediatrics.aappublications.org/content/106/3/e31>
6. Coyne-Beasley, et. al, (2005). Do partners with children know about firearms in their home? Evidence of a gender gap and implications for practitioners. Pediatrics, 115(6), pp.e662-e667. <http://pediatrics.aappublications.org/content/115/6/e662>
7. American Academy of Pediatrics, (2012) "Firearm-Related Injuries Affecting the Pediatrics Population" Pediatrics, Vol. 130(5), D1-D6, Available at: <http://pediatrics.aappublications.org/content/130/5/e1416.long#ref-30>
8. Prevention of Firearm Accidents in Children H-145.990. (2013). American Medical Association. Available at: <https://policysearch.ama-assn.org/policyfinder/detail/H-145.990?uri=%2FAMADoc%2FHOD.xml-0-547.xml>
9. Schuster, M A, et al. (2000) "Firearm Storage Patterns in US Homes with Children." American Journal of Public Health 90.4 588-594. Print.
10. Teret, Stephen P., et al. (2002) "Product-Oriented Approaches to Reducing Youth Gun Violence." The Future of Children, vol. 12, no. 2, pp. 119-131. JSTOR, www.jstor.org/stable/1602742
11. "Design Safety Standards for Handguns in California." Giffords Law Center to Prevent Gun Violence, 31 Oct. 2017. <http://lawcenter.giffords.org/design-safety-standards-for-handguns-in-california/>
12. Alcorn T. (2017) "Trends in Research Publications About Gun Violence in the United State." 1960- 2014. JAMA Intern Med. 177(1):124-126. doi:10.1001/jamainternmed.2016.7076 Available at: <https://jamanetwork.com/journals/jama/article-abstract/258298?redirect=true>
13. Stark, D., et al. (2017) "Funding and Publication of Research on Gun Violence and Other Causes of Death." JAMA; 317(1):84-85. doi:10.1001/jama.2016.16215 Available at: <https://jamanetwork.com/journals/jama/article-abstract/2595514>
14. Prevention of Unintentional Shooting Deaths Among Children H-145.979. (2009) American Medical Association. Available at: <https://policysearch.ama-assn.org/policyfinder/detail/Prevention%20of%20unintentional%20shooting%20deaths?uri=%2FAMADoc%2FHOD.xml-0-536.xml>
15. Law Center to Prevent Gun Violence RSS. Law Center to Prevent Gun Violence (2013) "Child Access Prevention Policy Summary", Available at: <http://smartgunlaws.org/child-access-prevention-policy-summary/>
16. Giffords Law Center to Prevent Gun Violence (2017) "Child Access Prevention." Available at: <http://lawcenter.giffords.org/gun-laws/policy-areas/child-consumer-safety/child-access-prevention/>
17. Law Center to Prevent Gun Violence (2013) "Child Access Prevention Policy Summary" Law Center to Prevent Gun Violence RSS., Available at: <http://smartgunlaws.org/child-access-prevention-policy-summary/>
18. DeSimone, J., et al. (2005) "The Effect of Child Access Prevention Laws on Non-Fatal Gun Injuries". National Bureau of Economic Research. Available at: <http://www.nber.org/papers/w11613>

RELEVANT AMA POLICY:

Prevention of Unintentional Shooting Deaths Among Children H-145.979

Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.

Citation: (Res. 204, I-98; Reaffirmed: BOT Rep. 23, A-09)

Prevention of Firearm Accidents in Children H-145.990

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(2) encourages state medical societies to work with other organizations to increase public education about firearm safety; and (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children.

Citation: Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 04, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(I-18)

Introduced by: Wisconsin

Subject: A Public Health Case for Firearm Regulation

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, Firearm deaths are a leading cause of preventable suicide, homicide, injury and disability in the USA;ⁱⁱ and

Whereas, In the USA in 2016, there were on average 97 firearm deaths per day, 35,476 total,ⁱ two thirds of which were suicides affecting mostly young black men and older white men;^{i,ii} and

Whereas, In the ten years ending in 2016, deaths from firearms totaled more than the cumulative deaths of American soldiers in WW II;ⁱⁱ and

Whereas, The Second Amendment to the U.S. Constitution specifies, “A well-regulated militia being necessary to the security of a free state, the right of the people to keep and bear arms shall not be infringed;”ⁱⁱⁱ and

Whereas, A militia is “generally an army or some other fighting organization of non-professional soldiers, citizens of a nation, or subjects of a state, who can be called upon for military service during a time of need;”^{iv} and

Whereas, The Second Amendment to the U.S. Constitution literally mandates that such militia be “well-regulated;” and

Whereas, Firearm regulation that does not violate the Second Amendment to the U.S. Constitution is not difficult to imagine; and

Whereas, A recent state-of-the-art systematic review of firearm regulation in the USA showed that firearm regulation was generally associated with decreased rates of firearm homicides;ⁱⁱ and

Whereas, In that same review, laws that particularly strengthened background checks and permit-to-purchase are associated with firearm homicide reductions of 29-40%;ⁱⁱ and

Whereas, The U.S. Congress in 1996 inserted language into the Centers for Disease Control and Prevention appropriation bills that essentially prevented it from conducting and funding firearm-related research;^v and

Whereas, Firearms are exceedingly efficient and lethal killing instruments easily classifiable as extremely hazardous to the health of the public; and

Whereas, U.S. physicians have begun to organize to promote firearm legislation and regulation^{vi} suggesting the time for action by organized medicine has arrived; therefore be it

1 RESOLVED, That our American Medical Association support a public health approach to
2 evidence-based firearm laws and regulations that do not conflict with the Second Amendment to
3 the U.S. Constitution (New HOD Policy); and be it further

4
5 RESOLVED, That our AMA oppose barriers to firearm safety. (New HOD Policy)

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

Received: 09/25/18

RELEVANT AMA POLICY

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;

(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and

(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18

Epidemiology of Firearm Injuries D-145.999

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms.

Citation: Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13; Reaffirmation: A-18

Data on Firearm Deaths and Injuries H-145.984

The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.

Citation: (Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-13)

Removing Restrictions on Federal Funding for Firearm Violence Research D-145.994

Our AMA will provide an informational report on recent and current organizational actions taken on our existing AMA policies (e.g. H-145.997) regarding removing the restrictions on federal funding for firearms violence research, with additional recommendations on any ongoing or proposed upcoming actions.

Citation: Res. 201, I-16

Gun Regulation H-145.999

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

Citation: Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and

(2) will actively lobby Congress to lift the gun violence research ban.

Citation: Res. 1011, A-16; Reaffirmation: A-18

ⁱ Wintemute GJ. What you can do to stop firearm violence. *Ann Intern Med* 2017;167:886-887.

ⁱⁱ Rowhani-Rahbar A, Rivara FP. Firearm injury after gun shows: Evidence to gauge the potential impact of Regulatory Interventions. *Ann Intern Med* 2017;167:888-889.

ⁱⁱⁱ https://en.wikipedia.org/wiki/Second_Amendment_to_the_US_Constitution. Accessed January 19, 2018.

^{iv} <https://en.wikipedia.org/wiki/Militia>, accessed January 29, 2018

^v Kellerman AL, Rivara FP. Silencing the science on gun research. *JAMA* 2013;309:549-550.

^{vi} Kuehn BM. Medical News and Perspectives: Physicians Join Frontline Efforts to Curb Gun Injuries, Deaths. *JAMA* January 2018, in print.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-18)

Introduced by: American Academy of Pediatrics

Subject: Extending the Medical Home to Meet Families Wherever They Go

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, The Medical Home model for care has been demonstrated to improve patient
2 outcomes and reduce total cost of care; and
3

4 Whereas, Technologic advances are empowering physician practices to extend their reach to
5 care for families in innovative ways including Telehealth; and
6

7 Whereas, Current scope of licensure in the majority of states limits physician practice abilities to
8 continue to meet the needs of their families when they travel outside the state in which the
9 physician is licensed; and
10

11 Whereas, Some states have joined the Interstate Medical Licensure Compact to facilitate
12 multistate licensure for physicians; and
13

14 Whereas, Payers provide telehealth options for patients who need to access primary care
15 services at times when access to the office of the primary care physician is difficult or
16 impossible; and
17

18 Whereas, Most primary care physicians are available to talk with patients, or participate in
19 telehealth primary care encounters, on a 24-7 basis; and
20

21 Whereas, Entrepreneurial telehealth for-profit entities are contracting with payers to provide
22 inferior quality telehealth primary care, delivered by non-physician providers, for patients; and
23

24 Whereas, The primary care physician who knows the patient and has 24-7 access to the
25 medical records of the patient will provide higher quality and more cost-effective health care for
26 the patient than will an out-of-state urgent care center, a hospital emergency department, or a
27 for-profit telehealth entity; therefore be it
28

29 RESOLVED, That our American Medical Association develop model legislation to permit
30 primary care physicians, who work in medical homes/primary care practices that satisfy the
31 National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home Recognition
32 Program guidelines, and who have documented a face-to-face patient-care relationship, to
33 provide telehealth services for the patient when the patient travels to any of the fifty states.
34 (Directive to Take Action)

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

Received: 10/10/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(I-18)

Introduced by: American Society of Clinical Oncology

Subject: Medicare Part B Competitive Acquisition Program (CAP)

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, The Competitive Acquisition Program (CAP) was introduced in 2006 as a voluntary
2 program in which physicians have the option to acquire drugs from vendors who are selected in
3 a competitive bidding process¹; and
4

5 Whereas, CAP was intended to save physicians time and paperwork, while also lowering drug
6 costs for beneficiaries and the Medicare program; and
7

8 Whereas, CAP was suspended by CMS due to lack of vendor competition, lack of physician
9 participation and limited cost savings; and
10

11 Whereas, The CMS Center for Medicare and Medicaid Innovation (CMMI) issued a Request for
12 Information (RFI) in July 2018 seeking public feedback on leveraging the authority for the CAP
13 for Part B drugs for a potential CMS Innovation Center model²; and
14

15 Whereas, CAP modifications must protect patients and practices from unexpected financial
16 toxicity; therefore be it

¹ Centers for Medicare and Medicaid Services. *Competitive Acquisition for Part B Drugs & Biologicals*. 2013. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/CompetitiveAcquisforBios/index.html> (Accessed September 19, 2018).

² Department of Health and Human Services, Centers for Medicare and Medicaid Services. *Request for Information on Leveraging the Authority for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals for a Potential CMS Innovation Center Model*. 83 Federal Register 147 (37212-37217). <https://www.gpo.gov/fdsys/pkg/FR-2018-07-31/pdf/2018-15958.pdf> (Accessed September 19, 2018).

1 RESOLVED, That our American Medical Association advocate that any revised Medicare Part B
2 Competitive Acquisition Program meet the following standards to improve the value of the
3 program by lowering the cost of drugs without undermining quality of care:

4 (1) it must be genuinely voluntary and not penalize practices which choose not to
5 participate;

6 (2) it should provide supplemental payments to support complex care coordination
7 and management for cancer patients, including reimbursement for costs associated
8 with the administration of anticancer drugs such as special handling and storage for
9 hazardous drugs;

10 (3) it should permit flexibility such as allowing for variation in orders that may occur
11 on the day of treatment, and allow for the use of CAP-acquired drugs at multiple
12 office locations;

13 (4) it should allow practices to choose from multiple vendors to ensure competition,
14 and should also ensure that vendors meet appropriate safety and quality standards;

15 (5) it should include robust and comprehensive patient protections which include
16 preventing delays in treatment, helping patients find assistance or alternative
17 payment arrangements if they cannot meet the cost-sharing responsibility, and
18 vendors should bear the risk of non-payment of patient copayments in a way that
19 does not penalize the physician; and

20 (6) it should not be tied to negotiated discounts such as rebates to pharmacy benefit
21 managers given in exchange for implementing utilization management policies like
22 step therapy. (New HOD Policy)

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

Received: 10/11/18

RELEVANT AMA POLICY

Strengthening Medicare Through Competitive Bidding H-330.886

1. Our AMA supports the following principles to guide the use of competitive bidding among health insurers in the Medicare program:

a. Eligible bidders should be subject to specific quality and financial requirements to ensure sufficient skill and capacity to provide services to beneficiaries.

b. Bidding entities must be able to demonstrate the adequacy of their physician and provider networks.

c. Bids must be based on a clearly defined set of standardized benefits that should include, at a minimum, all services provided under the traditional Medicare program and a cap on out-of-pocket expenses.

d. Bids should be developed based on the cost of providing the minimum set of benefits to a standardized Medicare beneficiary within a given geographic region.

e. Geographic regions should be defined to ensure adequate coverage and maximize competition for beneficiaries in a service area.

f. All contracting entities should be required to offer beneficiaries a plan that includes only the standardized benefit package. Expanded benefit options could also be offered for beneficiaries willing to pay higher premiums.

g. Processes and resources must be in place to provide beneficiary education and support for choosing among alternative plans.

2. Our AMA supports using a competitive bidding process to determine federal payments to Medicare Advantage plans.

Citation: (CMS Rep. 7, I-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(I-18)

Introduced by: American Society of Clinical Oncology

Subject: Opposition to Medicare Part B to Part D Changes

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, The Administration's "American Patients First Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs" proposes moving drugs from Medicare Part B to Part D if the move would achieve savings; and

Whereas, 9 million Part B beneficiaries do not have Part D coverage¹ and would therefore be at risk of losing coverage or experiencing higher out-of-pocket costs if this were implemented; and

Whereas, Co-insurance and out-of-pocket costs for therapies provided under Medicare Part D plans are typically higher than cost for therapies covered under Part B and that difference can be financially devastating for patients; and

Whereas, Shifting drugs from Part B to Part D would heighten the role that pharmacy benefit managers (PBMs) play in patient care even though they already generate issues such as treatment delays, medication switching without physician notification, and unnecessary administrative burdens; and

Whereas, Most Part B beneficiaries have supplemental insurance through Medigap programs that assist with Part B cost sharing and would not assist with Part D cost sharing; and

Whereas, There is insufficient data to suggest that moving Part B drugs to Part D would result in savings, as Acumen², Avalere³ and HHS⁴ studies all vary on the outcome of this move; and

Whereas, Physician payments for patient services and reimbursement for drugs together form the total resources available for practices to treat patients, thus it is vital to have an effective system for drug coverage in order to ensure optimal care and patient outcomes; therefore be it

RESOLVED, That our American Medical Association advocate against Medicare changes which would recategorize Medicare Part B drugs into Part D. (New HOD Policy)

¹ Medicare Payment Advisory Commission. *Health Care Spending and the Medicare Program: A Data Book*. Washington, DC: MedPAC, June, 2018. http://www.medpac.gov/docs/default-source/data-book/jun18_databookentirereport_sec.pdf?sfvrsn=0 (Accessed October 3, 2018)

² Marrufo G, Rusev E, Piccinini K, Coombs E, Ueda K, and Schechter E. *Estimating the Effects of Consolidating Drugs under Part D or Part B*. Burlingame, CA: Acumen, LLC, 2011. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Acumen_B_to_D_Final_Report_2011.pdf (Accessed September 17, 2018).

³ Brow M and Kane R. *Avalere Analysis Highlights Complexities of Transitioning Medicare Part B Drugs into Part D*. May 21, 2018. http://avalere.com/expertise/life-sciences/insights/avalere-analysis-highlights-complexities-of-transitioning-medicare-part-b-d?utm_source=newsletter&utm_medium=email&utm_campaign=transitioning-medicare-part-b-d (Accessed September 17, 2018)

⁴ Leavitt M. *Department of Health and Human Services Report to Congress: Transitioning Medicare Part B Covered Drugs to Part D*. 2005. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/RtC_PtbtoPtD_2005_4.pdf (Accessed September 17, 2018).

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

Received: 10/11/18

RELEVANT AMA POLICY

Opposition to the CMS Medicare Part B Drug Payment Model D-330.904

1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.
2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.
3. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients.
4. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.

Citation: Res. 241, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(I-18)

Introduced by: Colorado

Subject: Alternatives to Tort for Medical Liability

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, The stated purpose of tort mediated malpractice litigation is threefold:

- 2 1. To compensate patients harmed during the course of medical care;
- 3 2. To identify and hold accountable doctors and other clinicians for provision of
- 4 inappropriate or unsafe care;
- 5 3. To make medical care safer through exposure of negligent and flawed practice;
- 6 and thus identify areas for improvement; and
- 7

8 Whereas, Patients generally have no recourse other than medical tort actions to be made whole
9 after medical injury; and

10
11 Whereas, Linking compensation for harm to liability for negligence encourages lawsuits when
12 there is no causal linkage between care and outcome (e.g. most cases of cerebral palsy¹); and

13
14 Whereas, The tort system typically takes 3 years to resolve medical malpractice cases and
15 usually in favor of defendants leaving most harmed patients uncompensated at the end of a
16 long, inefficient and expensive process; and

17
18 Whereas, Only a small number of medical errors trigger a tort action leaving most cases of
19 medical harm unaddressed; and

20
21 Whereas, Most medical injuries are not the result of negligence²; and

22
23 Whereas, The usual course of litigation over adverse outcomes sets patients and their doctors
24 in adversarial positions when they should be most aligned to respond therapeutically; and

25
26 Whereas, According to the IOM's "To err is human" report, "...clinicians working in a culture of
27 blame and punishment do not report all errors, primarily because they fear punishment ... Fears
28 of reprisal and punishment have led to a norm of silence. But silence kills, and health care
29 professionals need to have conversations about their concerns ... including errors and
30 dangerous behavior of coworkers.⁶² ... When individuals and organizations are able to move
31 from individual blame toward a culture of safety, where the blame and shame of errors is
32 eliminated and reporting is rewarded, organizations are enabled to institutionalize reporting
33 systems and increase reporting of all types of errors.^{64, 65} ... clinicians and others must know
34 that safety can be improved by non-punitive reporting of error and that organizational flaws
35 cause errors.¹;" and

¹ <https://www.cdc.gov/ncbddd/cp/causes.html>

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3576054/>

1 Whereas, Research has shown a 5% cost reduction in hospital costs when the threat of tort
2 litigation is removed³; and
3

4 Whereas, Our AMA does have considerable policy on medical liability reform (H-435.973,
5 H-435.969, D 435.992), but none of these address the type of reform that is suggested below
6 for further study; therefore be it
7

8 RESOLVED, That our American Medical Association review options for alternatives to the tort
9 system that will assure fair compensation to individuals harmed in the process of receiving
10 medical care and separately identify and hold accountable physicians and other practitioners for
11 dangerous or unacceptable practice as well as identify opportunities for improving systems to
12 maximize the safety of medical care (as in New Zealand and other countries) (Directive to Take
13 Action); and be it further
14

15 RESOLVED, That our AMA develop new policy which can be used for advocacy or
16 development of model state legislation to replace the current tort system. (Directive to Take
17 Action)

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

Received: 10/05/18

³ <http://www.nber.org/papers/w24846>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-18)

Introduced by: Indiana

Subject: Promotion and Education of Breastfeeding

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, There is considerable science-based evidence for the benefits of breastfeeding over
2 the use of commercial formulas for both infant and mother; and
3

4 Whereas, The rate of breastfeeding of infants under the age of six months around the world is
5 only 40 percent, and
6

7 Whereas, The representatives of United States government to the World Health
8 Assembly/World Health Organization vigorously discouraged a resolution by that body to
9 advocate the preference and emphasize the health benefits of breastfeeding; and
10

11 Whereas, Mothers who wish to nurse still face some substantial impediments in many states;
12 therefore be it
13

14 RESOLVED, That our American Medical Association encourage the federal government to
15 legislate appropriate disclosures of the health benefits or limitations of synthetic infant formulas,
16 develop a breast feeding awareness education program, ensure that our representatives to
17 global meetings comport themselves in an unbiased manner that better represents a
18 compromise of all views of this particular issue and promote development of an affordable and
19 more equivalent substitute for breast milk for women who absolutely are unable to nurse (New
20 HOD Policy); and be it further
21

22 RESOLVED, That our AMA and all state medical associations support legislation for workplace
23 accommodation for nursing mothers in those states that do not already have such laws. (New
24 HOD Policy)

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

Received: 10/09/18

RELEVANT AMA POLICY

AMA Support for Breastfeeding H-245.982

1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.
2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.
3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.
4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).
5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.

Citation: CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12; Modified in lieu of Res. 409, A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(I-18)

Introduced by: Indiana

Subject: Supporting Mental Health Training Programs for Corrections Officers and
Crisis Intervention Teams for Law Enforcement

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, It is estimated that 168,082 individuals in Indiana have a severe mental illness (SMI),
2 of which 79,783 are currently untreated; and

3
4 Whereas, It is estimated that 2,413 individuals with SMI are in state, private and psychiatric
5 units in general hospitals in Indiana; and

6
7 Whereas, It is estimated that 6,393 individuals, or 15 percent of inmates in Indiana jails and
8 prisons, are SMI, making the odds of an SMI person being in jail or prison compared with being
9 treated in a hospital 2.6 to 1; and

10
11 Whereas, Corrections Officers (COs) can play a vital role in the proper treatment of offenders
12 with mental illness but generally receive very little training in mental health issues, making
13 violence between inmates and officers commonplace; and

14
15 Whereas, The National Alliance on Mental Illness (NAMI) Indiana chapter, in conjunction with
16 the Indiana University School of Medicine Department of Psychiatry, developed a 10-hour
17 education program that taught COs the major categories of psychiatric disorders, the biology
18 and treatment behind mental illness and effective ways to interact with mentally ill inmates,
19 which led to a significant reduction in the use of force by COs and the number of assaults with
20 bodily waste by the offenders; and

21
22 Whereas, According to a NAMI volunteer and member of the NAMI-Indiana Board of Directors,
23 the Indiana Department of Correction has embedded this course within its training curriculum for
24 prison COs, but this training is not in place in the majority of Indiana county jails; and

25
26 Whereas, Police officers may perceive mental health-related calls as unpredictable and
27 dangerous, which without adequate training in de-escalation could cause them to approach in a
28 manner that inadvertently escalates the situation; and

29
30 Whereas, It is estimated that 1 in 4 fatal police encounters ends the life of an individual with
31 SMI, making the risk of being killed during a police incident 16 times greater for individuals with
32 untreated mental illness than for other civilians; and

1 Whereas, A crisis intervention team (CIT) is an evidence-supported program that improves the
2 way law enforcement responds to individuals experiencing a mental health crisis by (1) building
3 partnerships between local law enforcement agencies, mental health providers and mental
4 health advocates, including but not limited to NAMI-Indiana; (2) providing officers with a 40-hour
5 curriculum consisting of lectures, on-site visitation, interaction with individuals with mental illness
6 and scenario-based de-escalation skill training; and 3) directing individuals with mental illness
7 toward treatment rather than incarceration; and
8

9 Whereas, The Fort Wayne Police Department's CIT reported diverting 99 percent of mental
10 health calls away from jail and into the mental health system in 2012; and
11

12 Whereas, Despite evidence showing that CIT improves public safety and significantly decreases
13 the number of arrests and re-arrests of SMI individuals, only 10 of 92 Indiana counties have an
14 active CIT program; and
15

16 Whereas, The AMA (1) continues to support jail diversion and community-based treatment
17 options for mental illness; (2) supports implementation of law enforcement-based crisis
18 intervention training programs for assisting those individuals with a mental illness, such as the
19 CIT model programs; and (3) supports federal funding to encourage increased community and
20 law enforcement participation in crisis intervention training programs; therefore be it
21

22 RESOLVED, That our American Medical Association support legislation and federal funding for
23 evidence-based training programs aimed at educating corrections officers in effectively
24 interacting with mentally ill populations in federal prisons. (New HOD Policy)

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

Received: 10/09/18

RELEVANT AMA POLICY

<https://policysearch.ama-assn.org/policyfinder/search/mental%20illness%20in%20jails/relevant/1/>.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(I-18)

Introduced by: Kentucky

Subject: Regulatory Relief from Burdensome CMS "HPI" EHR Requirements

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, The AMA has adopted principles that support that information technology available to physicians should support the physician's obligation to put the interests of patients first; and

Whereas, The information technology available to physicians should support the integrity and autonomy of physicians; and

Whereas, The AMA has affirmed a commitment to working with federal and state agencies, policy makers and other relevant stakeholders to improve EHRs; and

Whereas, Dissatisfaction among EHR end-users has contributed to physician burnout, and a diminished patient-physician relationship; and

Whereas, The Centers for Medicaid and Medicare Services (CMS) has determined that the History of Present Illness (HPI) cannot be performed incident to the physician by ancillary employees (ie, RN, LPN, MA or any other individual not able to bill Medicare for physicians' services); and

Whereas, The "keystroking" of the information contained in the HPI as contained by the EHR is NOT necessarily validation that a face to face visit by the physician was performed; and

Whereas, The "keystroking" of orders signed by a physician is acceptable to CMS and these orders are much more likely to directly result in error; and

Whereas, A physician's signature and declarative sentences regarding the nature of their work and involvement in the "HPI" portion of patient care should be sufficient to document their involvement in the care of the patient and doing so does not indicate that this information was treated as anything less than preliminary; therefore be it

RESOLVED, That our American Medical Association advocate for regulatory relief from the burdensome Centers for Medicare and Medicaid Services (CMS) History of Present Illness (HPI) requirements arbitrarily equating "keystroking" in an electronic health record (EHR) with validation of the fact that a face to face encounter has been performed by the physician/NPP (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the acceptance of the physician's electronic signature as substantiation and verification that the HPI was reviewed and appropriate additional information was obtained and recorded whomever "keystroked" this information. (Directive to Take Action)

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

Received: 10/05/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(I-18)

Introduced by: Maryland

Subject: Patient Privacy Invasion by the Submission of Fully Identified Quality Measure Data to CMS

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, There are two types of quality measure reports that are required to be produced by
2 Meaningful Use Stage 2 Certified EHRs: QRDA I reports provide detailed information about
3 patients including names, dates of birth, addresses, race and ethnicity and conditions such as
4 diabetes, drug and alcohol abuse, obesity, depression, etc. and QRDA III reports which are
5 summary reports which do not contain personal information about patients; and
6

7 Whereas, Patients do not give permission to submit the personally identified QRDA I reports for
8 either PQRS for Medicare and Medicaid or for Meaningful Use Quality Reporting; and
9

10 Whereas, The release of private information without permission can undermine the willingness
11 of patients to confide in their provider and may undermine the provider-patient relationship; and
12

13 Whereas, The quality measures include very sensitive information; and
14

15 Whereas, There are no guarantees that the database containing this personally identified
16 information can be protected from illegal access; and
17

18 Whereas, There are no guarantees that the database will not be released deliberately, by act of
19 law or regulation, sometime in the future, without patient permission; therefore be it
20

21 RESOLVED, That our American Medical Association work to establish regulation and/or
22 legislation requiring that all quality measure data be collected in summary format only with no
23 personally identified information included. (Directive to Take Action)

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

Received: 10/11/18

RELEVANT AMA POLICY

3.1.1 Privacy in Health Care

Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.

Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:

- (a) Minimize intrusion on privacy when the patients privacy must be balanced against other factors.
- (b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.
- (c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.

[AMA Principles of Medical Ethics: I,IV](#)

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

Patient Privacy and Confidentiality H-315.983

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:

(a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public

policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures.

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to

comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

Citation: BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep.

36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00;

Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep.

19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep.

24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07;

Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12; Reaffirmed: BOT Rep. 17,

A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res.

232, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(I-18)

Introduced by: Michigan

Subject: Permanent Reauthorization of the State Children's Health Insurance Program

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Our AMA supports health insurance coverage for all children as a national priority;
2 and

3
4 Whereas, The State Children's Health Insurance Program (SCHIP) provides comprehensive
5 health care insurance to over 8.9 million children and 360,000 pregnant women across the
6 country; and

7
8 Whereas, The purpose of SCHIP is to provide health insurance to children from
9 socioeconomically disadvantaged backgrounds; and

10
11 Whereas, Children are covered by SCHIP if their parents earn too much for Medicaid but cannot
12 afford private insurance; and

13
14 Whereas, The proportion of uninsured children dropped from 15 percent to 9 percent of all
15 children since SCHIP's establishment in 1997 and the rates of uninsured children within the
16 typical SCHIP family income range fell from 22.8 percent to 6.7 percent from 1997 to 2015; and

17
18 Whereas, Children in SCHIP have better access to care, fewer unmet needs, better educational
19 performance, and greater financial protection compared to when they were uninsured; and

20
21 Whereas, SCHIP is jointly funded by federal and state governments, and funds are
22 administered individually at the state level; and

23
24 Whereas, Federal funding for SCHIP expired on September 30, 2017, because of political
25 arguments unrelated to health care and stable funding was not restored until January 23, 2018;
26 and

27
28 Whereas, During the first four months of FY 2018, states operated SCHIP without renewal of
29 federal funding until Congress extended SCHIP with a 6-year extension on January 22, 2018;
30 and

31
32 Whereas, Prior to the 6-year extension, 31 states were projected to exhaust SCHIP funds by
33 March 2018 and by the end of fiscal year 2018, all 50 states would have exhausted remaining
34 CHIP funding; and

35
36 Whereas, During this lapse in funding, 14 states planned on freezing, phasing out, or
37 terminating coverage for children once their funds ran out, which would have left 611,052
38 children without health insurance on February 1, 2018; and

1 Whereas, Seven other states planned to close or cap total enrollment, three planned to
2 decrease or terminate funds for pregnant women, and a handful would have transitioned
3 children from CHIP to Medicaid programs; thereby, increasing state costs through the lower
4 Medicaid reimbursement rate; and

5
6 Whereas, During previous state freezes in SCHIP enrollment, affected children went almost
7 entirely without access to health care services and families faced financial hardship; and

8
9 Whereas, A permanent extension and reauthorization of SCHIP would prevent these vulnerable
10 populations from going without access to health care and would prevent SCHIP from being
11 inappropriately used in future political arguments; and

12
13 Whereas, Long-term funding of SCHIP saves money for state and federal governments,
14 evidenced by the Congressional Budget Office's official estimates stating that a five-year CHIP
15 extension would cost \$800 million but a 10-year extension would save \$6 billion; and

16
17 Whereas, Despite SCHIP's current authorization lasting for 10 years, multiple United States
18 Senators have advocated for a permanent reauthorization of CHIP, which would save money for
19 state and federal governments, as well as provide certainty to those governments and the
20 families who need it; therefore be it

21
22 RESOLVED, That our American Medical Association amend policy H-290.971, "Expanding
23 Enrollment for the State Children's Health Insurance Program (SCHIP)," by addition and
24 deletion to read as follows:

25
26 Our AMA continues to support:

- 27 a. health insurance coverage of all children as a strategic priority;
28 b. efforts to expand coverage to uninsured children who are eligible for the State
29 Children's Health Insurance Program (SCHIP) and Medicaid through improved and
30 streamlined enrollment mechanisms;
31 c. the permanent reauthorization of SCHIP ~~in 2007~~; and
32 d. supports the use of enrollment information for participation in the Special
33 Supplemental Nutrition Program for Women, Infants, and Children (WIC) and/or the
34 federal school lunch assistance program as documentation for SCHIP eligibility in
35 order to allow families to avoid duplication and the cumbersome process of re-
36 documenting income for child health coverage (Modify Current HOD Policy); and be it
37 further

1 RESOLVED, That our American Medical Association amend policy D-290.982, "State
2 Children's Health Insurance Program Reauthorization (SCHIP)," by addition and deletion
3 to read as follows:
4

5 1. Our AMA strongly supports the permanent reauthorization of the State Children's
6 Health Insurance Program ~~reauthorization~~ and will lobby toward this end.

7 2. Our AMA will lobby Congress to:

8 a. provide performance-based financial assistance for new coverage costs with
9 expanded coverage of uninsured children through SCHIP through an enhanced
10 federal match;

11 b. allow states to use SCHIP funds to augment employer-based coverage;

12 c. allow states to explicitly use SCHIP funding to cover eligible pregnant women;

13 d. allow states the flexibility to cover all eligible children residing in the United States
14 and pregnant women through the SCHIP program without a mandatory waiting
15 period;

16 e. provide \$60 billion in additional funding for SCHIP to ensure adequate funding of
17 the SCHIP program and incentivize states to expand coverage to qualified children,
18 and support incentives for physicians to participate; and

19 f. ensure predictable funding of SCHIP in the future.

20 3. Our AMA will urge Congress to provide targeted funding for SCHIP enrollment
21 outreach (Modify Current HOD Policy); and be it further
22

23 RESOLVED, That our AMA actively lobby the United States Congress for a permanent
24 reauthorization of the Children's Health Insurance Program. (Directive to Take Action)

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

Received: 10/10/18

RELEVANT AMA POLICY

Expanding Enrollment for the State Children's Health Insurance Program (SCHIP) H-290.971

Our AMA continues to support:

a. health insurance coverage of all children as a strategic priority;

b. efforts to expand coverage to uninsured children who are eligible for the State Children's Health Insurance Program (SCHIP) and Medicaid through improved and streamlined enrollment mechanisms;

c. the reauthorization of SCHIP in 2007; and

d. supports the use of enrollment information for participation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and/or the federal school lunch assistance program as documentation for SCHIP eligibility in order to allow families to avoid duplication and the cumbersome process of re-documenting income for child health coverage.

Citation: (Res. 118, A-07; CMS Rep. 1, A-07; Reaffirmation A-14)

Enhanced SCHIP Enrollment, Outreach, and Reimbursement H-290.976

1. It is the policy of our AMA that prior to or concomitant with states' expansion of State Children's Health Insurance Programs to adult coverage, our American Medical Association urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.

2. Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100% of RBRVS Medicare allowable.

Citation: Res. 103, I-01; Reaffirmation A-07; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, I-14;

Reaffirmation A-15; Reaffirmed: CMS Rep. 3, A-15; Reaffirmation: A-17

State Children's Health Insurance Program Reauthorization (SCHIP) D-290.982

1. Our AMA strongly supports the State Children's Health Insurance Program reauthorization and will lobby toward this end.
 2. Our AMA will lobby Congress to:
 - a. provide performance-based financial assistance for new coverage costs with expanded coverage of uninsured children through SCHIP through an enhanced federal match;
 - b. allow states to use SCHIP funds to augment employer-based coverage;
 - c. allow states to explicitly use SCHIP funding to cover eligible pregnant women;
 - d. allow states the flexibility to cover all eligible children residing in the United States and pregnant women through the SCHIP program without a mandatory waiting period;
 - e. provide \$60 billion in additional funding for SCHIP to ensure adequate funding of the SCHIP program and incentivize states to expand coverage to qualified children, and support incentives for physicians to participate; and
 - f. ensure predictable funding of SCHIP in the future.
 3. Our AMA will urge Congress to provide targeted funding for SCHIP enrollment outreach.
- Citation: (Res. 117, A-07; Res. 118, A-07; Res. 119, A-07; Reaffirmation A-14)

Protecting Children, Adolescents and Young Adults in Medicaid and the State Children's Health Insurance (SCHIP) Program D-290.985

Our AMA will actively: (1) encourage state and county medical societies to advocate for initiatives to ensure that all eligible children, adolescents, and young adults are enrolled in Medicaid and SCHIP; (2) advocate for federal and state funding for Medicaid and SCHIP so that funding is sufficient to support enrollment of and provision of necessary services to all eligible children, adolescents, and young adults; and (3) encourage state and county medical societies to work to ensure that services to children, adolescents, and young adults meet Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Standards.

Citation: (Res. 108, A-06; Reaffirmation A-14)

SOURCES

1. American Medical Association. (2014) "Expanding Health Enrollment for the State Children's Health Insurance Program." Available at <https://policysearch.ama-assn.org/policyfinder/detail/children's%20health%20insurance%20program?uri=%2FAMADoc%2FHOD.xml-0-2129.xml>.)
2. American Medical Association. (2014) "State Children's Health Insurance Program Reauthorization." Available at <https://policysearch.ama-assn.org/policyfinder/detail/children's%20health%20insurance%20program?uri=%2FAMADoc%2Fdirectives.xml-0-785.xml>.
3. Kaiser Family Foundation. (2018) "Number of Children Ever Enrolled in CHIP Annually." Available at <https://www.kff.org/other/state-indicator/annual-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.
4. Healthcare.gov. (2018) "Children's Health Insurance Program." Available at <https://www.healthcare.gov/glossary/childrens-health-insurance-program-chip/>.
5. Mathematica Policy Research Urban Institute. (2014) "CHIPRA Mandated Evaluation of the Children's Health Insurance Program: Final Findings." Available at <https://www.medicaid.gov/chip/downloads/chip-report-congress-2014.pdf>
6. Kaiser Family Foundation. (2018) "Summary of the 2018 CHIP Funding Extension." Available at <https://www.kff.org/medicaid/fact-sheet/summary-of-the-2018-chip-funding-extension/>.
7. Kaiser Family Foundation. (2017) "State Plans for CHIP as Federal CHIP Funds Run Out." Available at <https://www.kff.org/medicaid/fact-sheet/state-plans-for-chip-as-federal-chip-funds-run-out/>.)
8. Kaiser Commission on Medicaid and the Uninsured. (2017) "The North Carolina Health Choice Enrollment Freeze of 2001." Available at <https://kaiserfamilyfoundation.files.wordpress.com/2002/12/4081-north-carolina-health-choice.pdf>.
9. Kaiser Family Foundation. (2011) "The Arizona KidsCare CHIP Enrollment Freeze: How Has it Impacted Enrollment and Families?" Available at <https://www.kff.org/medicaid/issue-brief/the-arizona-kidscare-chip-enrollment-freeze-how/>.
10. POLITICO. (2017) "Children's Health Funding Hangs in the Balance as Congress Leaves Town." Available at <https://www.politico.com/story/2017/12/21/chip-childrens-health-insurance-program-fate-253869>.
11. Congressional Budget Office. "Cost Estimate of Extending the Children's Health Insurance Program for 10 Years." Available at <https://www.cbo.gov/publication/53459>.
12. Recommendations for the Future of CHIP and Children's Coverage. MACPAC. January 2017.
13. Centers for Medicare & Medicaid Services (CMS): Children's Health Insurance Program (CHIP). CMS. February 12, 2017. <https://www.hhs.gov/about/budget/fy2017/budget-in-brief/cms/chip/index.html>.
14. CHIP State Program Information. <https://www.medicaid.gov/chip/state-program-information/index.html>.
15. Summary of 2018 CHIP Funding Extension.
16. Luthi, S. Congress' CHIP patch accelerates rate states will run out of money. December 20, 2017. <http://www.modernhealthcare.com/article/20171220/NEWS/171229996/congress-chip-patch-accelerates-rate-states-will-run-out-of-money>.
17. Luthi, S. Congress punts CHIP to 2018 as states reach panic mode. December 21, 2017. <http://www.modernhealthcare.com/article/20171221/NEWS/171229982?ite=28197&ito=1155>.
18. When Will CHIP Funding Run Out? Georgetown University Health Policy Institute: Center for Children and Families.
19. State Plans for CHIP as Federal CHIP Funds Run Out. The Henry J. Kaiser Family Foundation. December 6, 2017. <https://www.kff.org/medicaid/fact-sheet/state-plans-for-chip-as-federal-chip-funds-run-out/>.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(I-18)

Introduced by: New York

Subject: Fairness in the Centers for Medicare & Medicaid Services Authorized Quality Improvement Organization's (QIO) Medical Care Review Process

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, The Center for Medicare & Medicaid has authorized quality improvement
2 organizations (QIO) to review medical services provided to Medicare patients; and
3

4 Whereas, The QIOs perform reviews of healthcare provided to Medicare patients to determine if
5 the care meets professionally recognized standards of care; and
6

7 Whereas, QIOs conduct these reviews to investigate complaints initiated by beneficiaries or the
8 patients' representatives about the health care they received; and
9

10 Whereas, The QIO peer reviewer is stated to be either a physician or other practitioner who
11 matches, as closely as possible, the variables of licensure, specialty, and practice setting of the
12 physician or practitioner under review; and
13

14 Whereas, When the QIO peer reviewer has no peer match available, the QIO may use another
15 physician reviewer without the same expertise; and
16

17 Whereas, The practitioner should be made aware when a reviewer is outside their area of
18 expertise; and
19

20 Whereas, The QIO should report annually on the number of peer reviews where the reviewer
21 was outside the reviewer's area of expertise; and
22

23 Whereas, If, after reviewing the Peer Review, the QIO determines that the Peer Reviewer has
24 identified a concern(s) for which the standard(s) of care was not met, the practitioner and/or
25 provider must be offered the opportunity to discuss the concern(s); and
26

27 Whereas, In instances when the practitioner and/or provider requests to submit new and/or
28 additional medical information, the QIO advises the practitioner and/or provider of his/her right
29 to request a reconsideration and that any new and/or additional medical information can be
30 considered during the reconsideration process; and
31

32 Whereas, Reconsideration is the additional review performed by the QIO when requested by the
33 beneficiary and/or the practitioner/provider when any of the parties is not pleased with the
34 outcome of the QIO's Initial Determination; and
35

36 Whereas, If a reconsideration review is undertaken, that constitutes the QIO final decision and
37 there are no further appeal rights available; and

Whereas, The only opportunity for the provider to respond is after the initial review and if the initial review finds no quality of care concern, the practitioner has no reason to respond; and

Whereas, If the beneficiary requests a reconsideration review and the finding is different from the initial finding, there is no recourse for the practitioner to respond; and

Whereas, If the second review has a quality of care concern identified, it is entered into the CMS database and if the QIO feels the issue may have significance beyond a single episode, a determination may be made that further intervention activities are required; and

Whereas, The CMS manual states that "In the rare instance when a Reconsideration Peer Reviewer identifies a new concern, the Reviewer must notify the QIO for the QIO to initiate processing of the newly identified concern at the Quality of Care Review Stage. The Reconsideration Peer Reviewer must not evaluate the concern because the matter will be eligible for review by an Initial Determination Peer Reviewer"; and

Whereas, QIOs are not interpreting this to allow for a new review in cases where the initial peer review found no quality of care issue; and

Whereas, CMS states that the Peer review is intended to be a collegial interaction with the goal of improving patient care; and

Whereas, The CMS QIO manual states that it is a "basic premise of fairness that beneficiaries, practitioners and/or providers are notified of the ability to file a request for reconsideration"; and

Whereas, By extension it is a basic premise of fairness that a practitioner should be able to defend an allegation of a deviation from a standard of care; and

Whereas, QIOs purport that their primary purpose is to identify areas where health care services can be improved and provide feedback to facilities and practitioners; and

Whereas, The QIOs state that the Peer review is intended to be a collegial interaction with the goal of improving patient care; therefore, be it

RESOLVED, That our American Medical Association seek by regulation and/or legislation to amend the Centers for Medicare and Medicaid Services (CMS) quality improvement organization (QIO) process to mandate an opportunity for practitioners and/or providers to request an additional review when the QIO initial determination peer review and the QIO reconsideration peer review are in conflict (Directive to Take Action); and be it further

RESOLVED, That our AMA seek by regulation and/or legislation to require CMS authorized QIOs to disclose to practitioners and/or providers when the QIO peer reviewer is not a peer match and is reviewing a case outside of their area of expertise (Directive to Take Action); and be it further

RESOLVED, That our AMA seek by regulation and/or legislation to require CMS authorized QIOs to disclose in their annual report, the number of peer reviews performed by reviewers without the same expertise as the physician being reviewed. (Directive to Take Action)

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

Received: 10/09/18

Reference:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/qio110c05.pdf>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(I-18)

Introduced by: New York

Subject: "Surprise" Out of Network Bills

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Legislation is under consideration in the United State Senate to create new rules for
2 payment of "surprise" out of network bills for patients treated in hospitals; and
3

4 Whereas, Components of this draft legislation would call for health insurers to pay for out of
5 network "surprise" bills as a percentage of in-network rates; and
6

7 Whereas, These "surprise" out of network bills are often the result of health insurers creating
8 narrow networks that limit patient choice and dis-incentivize physician participation; and
9

10 Whereas, Failure to ensure fair payment for out of network emergency care could have an
11 enormously adverse impact on the ability of hospitals to assure necessary availability of on-call
12 specialty physician care to meet patient need; and
13

14 Whereas, Several states across the country have enacted laws that provide patients protection
15 against these "surprise" bills; and
16

17 Whereas, The AMA has adopted policy H-285.904, "Out-of-Network Care," that includes a
18 component that "Insurers must meet appropriate network adequacy standards that include
19 adequate patient access to care, including access to hospital-based physician specialties"; and
20

21 Whereas, AMA Policy H-285.904 also states that "Out-of-network payments must not be based
22 on a contrived percentage of the Medicare rate or rates determined by the insurance company";
23 and
24

25 Whereas, AMA policy H-285.904 also states, with regard to "unanticipated" out of network
26 services, that "Minimum coverage standards should pay out-of-network providers at the usual
27 and customary out-of-network charges for services, with the definition of usual and customary
28 based upon a percentile of all out-of-network charges for the particular health care service
29 performed by a provider in the same or similar specialty and provided in the same geographical
30 area as reported by a benchmarking database. Such a benchmarking database must be
31 independently recognized and verifiable, completely transparent, independent of the control of
32 either payers or providers and maintained by a non-profit organization. The non-profit
33 organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or
34 health management organization"; and
35

36 Whereas, Current AMA policy does not expressly call for the AMA to advocate for federal
37 legislation consistent with these principles; and

1 Whereas, Current federal legislation does not address health insurer network adequacy
2 problems; and
3

4 Whereas, Federal legislation has the potential to pre-empt state laws that have been shown to
5 address these problems in ways that are fair to patients, health insurers, hospitals and
6 physicians; and
7

8 Whereas, Even if such federal legislation were to not pre-empt state law, it has the potential to
9 create new standards that states with existing "surprise" bill laws may seek to match; therefore
10 be it
11

12 RESOLVED, That our American Medical Association advocate that any federal legislation on
13 "surprise" out of network medical bills be consistent with AMA Policy H-285.904, "Out-of-
14 Network Care," and apply to ERISA plans not subject to state regulation (New HOD Policy); and
15 be it further
16

17 RESOLVED, That our AMA advocate that such federal legislation protect state laws that do not
18 limit surprise out of network medical bills to a percentage of Medicare or health insurance fee
19 schedules. (New HOD Policy)

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

Received: 10/10/18

RELEVANT AMA POLICY

Out-of-Network Care H-285.904

1. Our AMA adopts the following principles related to unanticipated out-of-network care:

A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.

C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

H. Mediation should be permitted in those instances where a physicians unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

Citation: Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(I-18)

Introduced by: Utah

Subject: Support for Interoperability of Clinical Data

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, As of 2016 78% of physicians and 96% of hospitals routinely use electronic health records (EHRs) during care,¹ and nationally only half of hospitals have necessary patient information electronically available from providers or sources outside their systems at the point of care²; and

Whereas, Accessing patient data through a health information exchange (HIE) in an emergency department has been shown to reduce hospital admissions, and decrease unneeded diagnostic imaging and procedures³; and

Whereas, An HIE increases provider access to data necessary for treatment such as results of tests conducted in another health care practice while lack of exchange may result in duplicate and unnecessary testing³⁻⁶; and

Whereas, An HIE has been shown to reduce net annual costs for patient care, even after accounting for costs related to the HIE,^{3,7} and cost reductions are seen in healthcare markets that have operational HIEs caring for Medicare patients^{8,9}; and

Whereas, Clinicians across the country need ready access to data from clinical settings outside their own to deliver cost effective, non-duplicative care for their patients; and to be competitive in new payment arrangements that incentivize coordinated care, reduction in unneeded testing and imaging, and a view of the health of their patient in and outside of the clinical setting; therefore be it

RESOLVED, That our American Medical Association review and advocate for the implementation of appropriate recommendations from the "Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care," a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services. (Directive to Take Action)

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

Received: 10/11/18

References

1. <https://dashboard.healthit.gov/quickstats/quickstats.php>
2. https://www.healthit.gov/sites/default/files/briefs/onc_data_brief_36_inter_operability.pdf
3. Frisse ME, Johnson KB, Nian H, et al. The financial impact of health information exchange on emergency department care. *Journal of the American Medical Informatics Association (JAMIA)*. 2011;19(3):328-33.
4. Lammers EJ, Adler-Milstein J, Kocher KE. Does health information exchange reduce redundant imaging: Evidence from emergency departments. 2014;52(3):227-234.
5. Bailey JE, Wan JY, Mabry LM, et al. Does health information exchange reduce unnecessary neuroimaging and improve quality of headache care in the emergency department? *Journal of General Internal Medicine*. 2013;28(2):176-83.
6. (Fontaine P, Ross SE, Zink T, Schilling LM. Systematic review of health information exchange in primary care practices. *Journal of the American Board of Family Medicine (JABFM)*. 2010;23(5):655-70.
7. Stewart BA, Fernandes S, Rodriguez-Huertas E, Landzberg M. A preliminary look at duplicate testing associated with lack of electronic health record interoperability for transferred patients. *Journal of the American Medical Informatics Association (JAMIA)*. 2010;17(3):341-44.
8. Adjerid, Idris and Adler-Milstein, Julia and Angst, Corey M., Reducing Medicare Spending Through Electronic Information Exchange: The Role of Incentives and Exchange Maturity (April 14, 2016). Available at SSRN: <https://ssrn.com/abstract=2765098>
9. <http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/electronic-health-information-exchange>
10. <https://www.ncbi.nlm.nih.gov/pubmed/29564850>; <https://www.thieme-connect.com/products/ejournals/html/10.1055/s-0038-1637007>.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(I-18)

Introduced by: American College of Rheumatology, American Academy of Allergy, Asthma & Immunology, American Academy of Dermatology, American Academy of Neurology, American Academy of Physical Medicine and Rehabilitation, American Association of Clinical Endocrinologists, American Clinical Neurophysiology Society, American Gastroenterological Association, American Psychiatric Association, American Society of Clinical Oncology, Endocrine Society, Infectious Diseases Society of America, Maryland, North American Neuro-Ophthalmology Society, Society for Investigative Dermatology, Kentucky, Georgia

Subject: CMS Proposal to Consolidate Evaluation and Management Services

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Our AMA and the state and specialty medical societies of the AMA federation are
2 committed to working with the Centers for Medicare and Medicaid Services (CMS) to reduce
3 provider burden and increase Medicare beneficiaries' access to appropriate care; and
4

5 Whereas, CMS is to be commended for recognizing the problems with the current evaluation
6 and management documentation guidelines and codes, and for including a significant proposal
7 to address them in the CY 2019 Medicare physician fee schedule proposed rule; and
8

9 Whereas, CMS in its physician fee schedule proposed rule put forward a plan to cut and
10 consolidate evaluation and management services, which would severely reduce Medicare
11 patients' access to care by cutting payments for complex office visits, adversely affecting the
12 care and treatment of patients with complex conditions; and
13

14 Whereas, The proposals to consolidate the billing codes for physician evaluation and
15 management so as to pay the same amount for office visits regardless of the complexity of the
16 patient would cut payments for visits that are currently reimbursed at higher levels than simple
17 or routine office visits, penalizing doctors who treat sicker or complex patients, or patients with
18 multiple conditions; and
19

20 Whereas, Payments from newly proposed add-on codes, which have been put forward with the
21 intention of protecting complex care by making up for severe cuts, are not certain and likely
22 would not be sufficient to ensure continued patient access, and moreover the application of new
23 codes to some specialties and not others would effectively result in CMS picking winners and
24 losers; and
25

26 Whereas, We agree with CMS' ultimate goal of increasing the amount of time physicians have
27 to spend with patients instead of paperwork and computers, but the collapsing of evaluation and
28 management codes would have an immediate and lasting effect of restricting patient access to
29 care; and

1 Whereas, CMS is expected to release the CY 2019 physician fee schedule final rule in
2 November of 2018, less than two months ahead of the proposed implementation date of
3 January 1, 2019; and
4

5 Whereas, Given the negative impacts of this well-intentioned proposal, CMS should not finalize
6 these concepts as proposed; and
7

8 Whereas, The physician community stands ready to work with CMS to identify alternative
9 approaches that would accomplish its goal of reducing paperwork and administrative burden
10 without endangering patient access to care, and while ensuring that physicians have the
11 resources they need to provide patients with the high-quality care they deserve; therefore be it
12

13 RESOLVED, That our American Medical Association actively seek and support congressional
14 action before January 1, 2019 that would prevent implementation of changes to consolidate
15 evaluation and management services as put forward in the CY 2019 Medicare physician fee
16 schedule proposed rule if CMS in the final rule moves forward with the consolidation of
17 evaluation and management services. (Directive to Take Action)

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

Received: 10/11/18

RELEVANT AMA POLICY

Medicare Guidelines for Evaluation and Management Codes H-70.952

Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services; (2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse; (3) urges CMS to adequately fund Medicare Carrier distribution of any documentation guidelines and provide funding to Carriers to sponsor educational efforts for physicians; (4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately reflected in the Resource Based Relative Value Scale (RBRVS); (5) will facilitate review and corrective action regarding the excessive content of the evaluation and management documentation guidelines in collaboration with the national medical specialty societies and to work to suspend implementation of all single system examination guidelines until approved by the national medical specialty societies affected by such guidelines; (6) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS; (7) urges CMS to establish a test period in a specific geographic region for these new guidelines to determine any effect their implementation will have on quality patient care, cost effectiveness and efficiency of delivery prior to enforcement of these mandated regulations; (8) opposes adoption of the Medicare evaluation and management documentation guidelines for inclusion in the CPT; and (9) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required.

Citation: (Sub. Res. 801, I-97; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10)

Preservation of Evaluation/Management CPT Codes H-70.985

It is the policy of the AMA to (1) oppose the bundling of procedure and laboratory services within the current CPT Evaluation/Management (E/M) services; (2) oppose the compression of E/M codes and support efforts to better define and delineate such services and their codes; (3) seek feedback from its members on insurance practices that advocate bundling of procedures and

laboratory services with or the compression of codes in the CPT E/M codes, and express its views to such companies on behalf of its members; (4) continue to work with the PPRC and all other appropriate organizations to insure that any modifications of CPT E/M codes are appropriate, clinically meaningful, and reflective of the considered views of organized medicine; and (5) work to ensure that physicians have the continued opportunity to use CPT as a coding system that is maintained by the medical profession.

Citation: (Sub. Res. 98, A-90; Reaffirmed by Res. 850, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10)

Preservation of Five Levels of Evaluation and Management Services D-70.979

Our AMA will communicate to the Centers for Medicare and Medicaid Services and to private payers that the current levels of Evaluation and Management services should be maintained and not compressed, with appropriate payment for each level.

Citation: Sub. Res. 804, I-01; Reaffirmation A-06; Reaffirmed in lieu of Res. 823, I-06; Modified: CMS Rep. 01, A-16

Reference Committee C

CME Report(s)

- 01 Competency of Senior Physicians
- 03 Developing Physician-Led Public Health / Population Health Capacity in Rural Communities
- 04 Reconciliation of AMA Policy on Primary Care Workforce
- 05* Reconciliation of AMA Policy on Medical Student Debt
- 06 Reconciliation of AMA Policy on Resident/Fellow Contracts and Duty Hours

Resolution(s)

- 951 Prevention of Physician and Medical Student Suicide
- 952 IMG Section Member Representation on Committees/Task Forces/Councils
- 953 Support for the Income-Driven Repayment Plans
- 954 VHA GME Funding
- 955 Equality for COMLEX and USMLE
- 956 Increasing Rural Rotations During Residency
- 957 Board Certifying Bodies
- 958* National Health Service Corps Eligibility
- 959* Physician and Medical Student Mental Health and Suicide
- 960* Inadequate Residency Slots
- 961* Protect Physician-Led Medical Education
- 962* Improve Physician Health Programs

REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION (I-18)
Competency of Senior Physicians
(Reference Committee C)

EXECUTIVE SUMMARY

Older physicians remain an essential part of the physician workforce as they continue to practice into their 70s and 80s. Although some studies of physicians have shown decreasing practice performance with increasing years in medical practice, the effect of age on any individual physician's competence can be highly variable. The call for increased accountability by the public has led regulators and policymakers to consider implementing some form of age-based competency screening to assure safe and effective practice. In addition, some hospitals and medical systems have initiated age-based screening, but there is no national standard. Older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice. It is critical that physicians take the lead in developing standards for monitoring and assessing their personal competency and that of fellow physicians to head off a call for nationally implemented mandatory retirement ages or imposition of guidelines by others that are not evidenced based.

The Council on Medical Education studied this issue and prepared its first report on this topic in 2015. American Medical Association (AMA) Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," was adopted and the Council, in collaboration with the Senior Physicians Section, identified organizations to work together to develop preliminary guidelines for screening and assessing the competency of the senior/late career physician. The AMA Work Group on Assessment of Senior/Late Career Physicians included key stakeholders that represented physicians, medical specialty societies, accrediting and certifying organizations, hospitals and other health care institutions, and patients' advocates as well as content experts who research physician competence and administer assessment programs.

The work group concurred that it was important to investigate the current screening practices and policies of the state medical and osteopathic boards, medical societies, large U.S. health systems, and remediation programs as well as to collect data and review the current literature to learn more about age and risk factors associated with the assessment of senior/late career physicians in the United States and internationally. This report summarizes the activities of the work group and additional research findings on this topic.

This report also outlines a set of guiding principles developed by the Council with extensive feedback from members of the work group as well as from other content experts who research physician competence and administer assessment programs. The guiding principles provide direction and serve as a reference for the development of guidelines for screening and assessing senior/late career physicians. The underlying assumption is that guidelines must be based on evidence and on the principles of medical ethics. Furthermore, guidelines should be relevant, supportive, fair, equitable, and transparent, and not result in undue cost or burden to senior physicians. The primary driver for the establishment of guidelines should be to fulfill the ethical obligation of the profession to the health of the public and patient safety.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-18

Subject: Competency of Senior Physicians

Presented by: Carol Berkowitz, MD, Chair

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

American Medical Association (AMA) Policy D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians,” directs our AMA to: “1) identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior/late career physicians remain able to provide safe and effective care for patients; and 2) convene organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings.”

The first report on this topic, Council on Medical Education Report 5-A-15, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians,” recommended that a work group be convened to further study the topic of assessing the competency of senior/late career physicians. This report summarizes the activities of the work group and additional research findings on this topic. This report also outlines a set of guiding principles to provide direction and serve as a reference for the development of guidelines for screening and assessing senior/late career physicians.

BACKGROUND: SCOPE OF THE ISSUE

Older physicians remain an essential part of the physician workforce. The total number of physicians 65 years and older has increased greatly from 50,993 in 1975 to 300,752 in 2017.¹ Physicians 65 and older currently represent 26.6 percent of all physicians in the United States.¹ Within this age group, two-fifths (40.6 percent) are actively engaged in patient care, while half (52.7 percent) are listed as inactive in the AMA Physician Masterfile.¹ Many physicians are hesitant to retire and may continue to practice into their 70s and 80s due to professional satisfaction, increased life expectancy, and concerns regarding financial security.²

Evidence supports findings that physical health and some cognitive abilities decline with aging.³ Research shows that cognitive dysfunction is more prevalent among older adults, although aging does not necessarily result in cognitive impairment.⁴ The effect of age on any individual physician’s competence can be highly variable, and aging is just one of several factors that may impact performance.^{2,5} Other factors may influence clinical performance, i.e., practice setting, lack of board certification, high clinical volume, certain specialty practices, etc.^{6,7} Fatigue, stress, burnout, and health issues unrelated to aging are also risk factors that can affect clinical performance.⁷ Performance also may be broadly determined by characteristics ranging from intelligence to personality.³ However, some attributes relevant to the practice of medicine—such as

wisdom, resilience, compassion, and tolerance of stress—may actually increase as a function of aging.^{5,8-11}

Although age alone may not be associated with reduced competence, the variation around cognitive abilities as physicians age suggests that the issue cannot be ignored. There are a limited number of valid tools for measuring competence/performance, but these tools are primarily used when a physician is “referred for cause.” In addition, physicians’ practices vary throughout the United States and from specialty to specialty. A few hospitals have introduced mandatory age-based evaluations, but there is no national standard.¹²⁻¹³ Furthermore, there is cultural resistance to externally imposed assessment approaches and concern about discriminatory regulatory policies and procedures.

Knowing when to give up practice remains an important decision for most doctors and a critically difficult decision for some.¹⁴ For this reason, physicians with decades of experience and contributions to medicine and to their patients, as they experience health changes that may or may not allow continued clinical practice, deserve the same sensitivity and respect afforded their patients.¹⁵ Shifting away from procedural work, allocating more time with individual patients, using memory aids, and seeking input from professional colleagues might help physicians successfully adjust to the cognitive changes that accompany aging.^{5,14}

It is in physicians’ best interest to proactively address issues related to aging in order to maintain professional self-regulation. Self-regulation is an important aspect of medical professionalism, and helping colleagues recognize their declining skills is an important part of self-regulation.¹⁶ Furthermore, contemporary methods of self-regulation (e.g., clinical performance measurement; continuing professional development requirements, including novel performance improvement continuing medical education programs; and new and evolving maintenance of certification programs) have been created by the profession to meet shared obligations for quality assurance and patient safety.

WORK GROUP MEETINGS

To fulfill the directive of Policy D-275.956, the Council on Medical Education, in collaboration with the Senior Physicians Section, identified organizations to participate in a joint effort to develop preliminary guidelines for screening and assessing the senior/late career physician. As summarized below, one work group meeting and two conference calls were convened to develop a research agenda that could guide those interested in this field and serve as the basis for guidelines supported by research findings.

March 16, 2016 Work Group Meeting

The work group meeting, held March 16, 2016, brought together key stakeholders that represented physicians, medical specialty societies, accrediting and certifying organizations, hospitals and other health care institutions, and patients’ advocates as well as content experts who research physician competence and administer assessment programs. Work group participants concurred that this first meeting raised important issues related to the rationale for developing guidelines to screen and assess the competence and practice performance of senior physicians, which are challenging for a number of reasons. Discussion centered around the evidence and factors related to competency and aging physicians, existing and needed policies, screening and assessment approaches, and legal requirements and challenges. Although current evidence and preliminary research pointed toward the need for developing guidelines, most work group participants felt that additional information/data should be gathered on aging physicians’ competence and practice performance. In

1 addition, the participants felt that a set of guiding principles should be developed to reflect the
 2 values and beliefs underlying any guidelines that may be developed for screening and assessing
 3 senior/late career physicians.

4
 5 *July 19, 2016 Work Group Conference Call*

6
 7 The purpose of this conference call was to convene a smaller group of participants to develop
 8 guiding principles to support the subsequent development of guidelines to screen and assess
 9 senior/late career physicians. During the call, the conversation focused upon the thresholds at
 10 which screening/assessment should be required. Although physicians of all ages can be assessed
 11 “for cause,” the group discussed whether age alone is a sufficient cause for some kind of
 12 monitoring beyond what is typical for all physicians. Other factors discussed included the influence
 13 of practice setting and medical specialty, as well as the metrics and standards for different settings
 14 that would have to be developed to determine at “what age” and “how do you test,” etc. The need
 15 for surveillance, associated risk factors, and the ability to take appropriate steps, if needed, were
 16 also discussed. It was noted that there is a need to be able to fairly and equitably identify physicians
 17 who may need help while assuring patient safety. It was also noted that very few hospitals have
 18 specific age guidelines, and that there was evidence that the number of disciplinary actions increase
 19 at ages 65 and 70. The cost of and who will pay for screening/assessments were also discussed.

20
 21 The group felt that more information and data were needed before the guiding principles could be
 22 finalized and agreed to reconvene after gathering more information and studying evidence-based
 23 data from the United States and other countries related to age and risk factors.

24
 25 *December 15, 2017 Work Group Conference Call*

26
 27 The purpose of this conference call was to reconvene the same smaller group of participants to
 28 review the literature and data that had been gathered, and to finalize guiding principles to support
 29 the subsequent development of guidelines to screen and assess senior/late career physicians.
 30 Background information to help guide the development of the guiding principles included:

- 31
 32 1. Results from a survey of members of the Federation of State Medical Boards (FSMB),
 33 Council of Medical Specialty Societies (CMSS), and International Association of Medical
 34 Regulatory Authorities (IAMRA) regarding the screening and assessment of senior
 35 physicians.
 36
 37 2. A literature review of available data related to senior physician screening and assessment,
 38 focusing on international work in this area.
 39
 40 3. Data from large health systems regarding their screening and assessment policies and
 41 procedures.
 42

43 Survey Results Related to Screening and Assessing Senior Physicians

44
 45 To support the development of guiding principles, data were gathered through surveys of
 46 professional associations (CMSS), state medical boards (FSMB), and international regulatory
 47 authorities (IAMRA). The goal was to learn if these organizations had processes in place to screen
 48 and assess senior physicians for clinical or cognitive competence, and if not, whether they had
 49 thought about developing such screening and assessment processes.

The survey data showed that most respondents were not screening or assessing senior physicians. A slightly larger number of respondents have thought about this, but those numbers were still fairly small.

Most respondents did not have clinical or cognitive screening/competence assessment policies in place. In addition, most did not know (42, or 46.7 percent) or were unsure (26, or 28.9 percent) whether other organizations had age-based screening in place. Regarding whether age-based screening should be included within physician wellness programs, 28 (32.9 percent) said yes, while nine (10.6 percent) said no, and 48 (56.5 percent) were unsure.

Respondents were asked if their organizations/boards offered educational resources regarding the effects of age on physician practice; eight (9.2 percent) said yes, 72 (82.8 percent) said no, and seven (8.0 percent) were unsure. The survey also asked organizations if they were interested in having resources that promoted physician awareness of screening aging physicians in practice. Very few groups offered these types of resources, but 100 percent (11) of IAMRA respondents, 60.8 percent (31) of FSMB respondents, and 25 percent (3) of CMSS respondents were interested in offering them.

Highlights from the Literature Review

A review of current literature focusing on age and risk factors associated with the assessment of senior/late career physicians in the United States and internationally is summarized below.

Peer-reviewed studies recently published focus on institutional policies related to cognitive assessment of senior physicians. Dellinger et al. concluded that as physicians age, a required cognitive evaluation combined with a confidential, anonymous feedback evaluation by peers and coworkers regarding wellness and competence would be beneficial both to physicians and their patients.¹⁷ The authors also recommended that large professional organizations identify a range of acceptable policies to address the aging physician, while leaving institutions the flexibility to customize the approach.¹⁷ Institutions such as Cooper University Health Care in Camden, New Jersey, are developing late career practitioner policies that include cognitive assessment with peer review and medical assessment to assure the hospital and physicians that competency is intact and that physicians can continue to practice with confidence.¹⁸

Studies related to professionalism, self-reporting, and peer review indicate that these methods are not always reliable.^{16, 19-20} Since early “red flags” of cognitive impairment may include prescription errors, billing mistakes, irrational business decisions, skill deficits, patient complaints, office staff observations, unsatisfactory peer review, patient injuries, or lawsuits, Soonsawat et al. encouraged improved reporting of impaired physicians by patients, peers, and office staff.² LoboPrabhu et al. suggested that either age-related screening for cognitive impairment should be initiated, or rigorous evaluation after lapses in standard of care should be the norm regardless of age.²¹

Any screening process needs to achieve a balance between protecting patients from harm due to substandard practice while at the same time ensuring fairness to physicians and avoiding any unnecessary reductions in workforce.³ A recent study of U.S. senior surgeons showed that a steady proportion of surgeons, even in the oldest age group (>65), are still active in new surgical innovations and challenging cases.²² Individual and institutional considerations require a dialogue among the interested parties to optimize the benefits while minimizing the risks for both.²³⁻²⁴

In Canada, the aging medical workforce presents a challenge for medical regulatory authorities charged with protecting the public from unsafe practice. Adler and Constantinou note that normal

aging is associated with some cognitive decline as part of the aging process, but physicians, who are highly educated individuals with advanced degrees may be less at risk.¹⁴

A review of the aging psychiatric workforce in Australia showed how specific cognitive and other skills required for the practice of psychiatry vary from those applied by procedural specialists.²⁵ The Australian medical boards are responsible for protecting the public from unsafe medical practice. There is some uniformity in the way that Australian regulatory bodies deal with impairment that supports the dual goals of protecting the public and rehabilitating the physician.²⁶ However, there are no agreed upon guidelines to help medical boards decide what level of cognitive impairment in a physician may put the public at risk.¹⁴ In Australia, the primary approach to dealing with older physicians (age 55 and older) is individualized and multi-levelled, beginning with assessment, followed by rehabilitation where appropriate; secondary measures proposed for older impaired physicians include early notification and facilitating career planning and timely retirement.²⁶

It is the responsibility of licensing bodies in New Zealand, Canada, and the United Kingdom to use reasonable methods to determine whether performance remains acceptable.²⁷ However, high performance by all physicians throughout their careers cannot be fully ensured.

A better understanding of physician aging and cognition can inform more effective approaches to continuous professional development and lifelong learning in medicine—a critical need in a global economy, where changing technology can quickly render knowledge and skills obsolete.⁴ The development of recertification programs, such as maintenance of certification (MOC) by the member boards of the American Board of Medical Specialties, provides an opportunity to study the knowledge base across the professional lifespan of physicians.²⁸⁻²⁹ For example, a recent study of initial certification and MOC examinees in the subspecialty of forensic psychiatry using a common item test question bank compared the two examinee groups' performance and demonstrated that performance for those younger than 50 was similar to those 60 and older, and that diplomates recertifying for the second time outperformed those doing so for the first time.³⁰

The Royal Australasian College of Surgeons developed strategies to support senior surgeons over 65 years of age (expected to be about 25 percent of surgeons by 2050) and a position statement that provides clear guidelines to aging surgeons, with a focus on continuing professional development.³¹⁻³² An assessment of the competence of practicing physicians in New Zealand, Canada, and the United Kingdom showed that “maintenance of professional standards” by continuing education did not identify the poorly performing physician; rather, assessment of clinical performance was needed.²⁷ The most common approach to assessment may be responsive—following a complaint—or periodic, either for all physicians or for an identified high-risk group. However, a single, valid, reliable, and practical screening tool is not available.²⁷

A literature review conducted in Europe to explore the effects of aging on surgeons' performance and to identify current practical methods for transitioning surgeons out of practice at the appropriate time and age, suggested that competence should be assessed at an individual level, focusing on functional ability over chronological age; this may inform retirement policies for surgeons, which differ worldwide.²² Research conducted in Canada suggested that some interventions (external support, deliberate practice, and education and testing) might prove successful in remediating older physicians, who should be tested more thoroughly.³³

Careful planning, innovative thinking, and the incorporation of new patterns of medical practice are all part of this complex transition of timing into retirement in the United States.^{23,34} A literature review that looked at retirement ages for doctors in different countries found that there is no

mandatory retirement age for doctors in most countries.³⁵ Anecdotal reports published in the *British Medical Journal* suggest that retirement has never been easy and is getting harder for some physicians because requirements for reappraisal and other barriers are discouraging some from considering part-time work after retirement.³⁶⁻³⁷ In Canada, Ireland, and India, the retirement age (65) is limited to public sectors only, but older physicians can continue to practice in the private sector.³⁵ In Russia and China, the mandated retirement age is 60 for men and 55 for women.³⁵

Studies show that doctors can mitigate the impact of cognitive decline by ceasing procedural work, allocating more time to each patient, using memory aids, seeking advice from trusted colleagues, and seeking second opinions.¹⁴ Peisah, et al. (Australia) proposed a range of secondary and primary prevention measures for dealing with the problem of the older impaired doctor; these included educating the medical community, encouraging early notification, and facilitating career planning and timely retirement of older doctors.²⁶ Racine (Canada) suggested that physicians retire before health or competency issues arise.³⁸ Lee (Canada) suggested that older practicing physicians consider slowing down in aspects of practice that require rapid cognitive processing and listen carefully to the concerns of colleagues, patients, friends, and family.³⁹ The University of Toronto, Department of Surgery, has developed Guidelines for Late Career Transitions that require each full-time faculty surgeon to undergo an annual assessment of academic and surgical activity and productivity. As surgeons age, the University creates individual plans for a decrease in on-call surgical responsibilities and encourages late-career surgeons to engage in greater levels of teaching, research, and administration.⁴⁰

How Some U.S. Organizations Are Addressing the Screening and Assessment of Competency of Senior Physicians

Since the call for increased accountability by the public has led regulators and policymakers to consider implementing some form of age-based competency screening to assure safe and effective practice,⁵ the work group concurred that it was important to investigate the current screening practices and policies of state medical and osteopathic boards, medical societies, large U.S. health systems, and remediation programs. Some of the more significant findings are summarized below.

All physicians must meet state licensure requirements to practice medicine in the United States. In addition, some hospitals and medical systems have initiated age-based screening,¹²⁻¹³ but there is no national standard. Older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice.

The American College of Surgeons (ACS) explored the challenges of assessing aging surgeons. Recognizing that the average age of the practicing surgeon is rising and approximately one-third of all practicing surgeons are 55 and older, the ACS was concerned that advanced age may influence competency and occupational performance. In January 2016, the ACS Board of Governors' Physician Competency and Health Workgroup published a statement that emphasized the importance of high-quality and safe surgical care.³⁹ The statement recognized that surgeons are not immune to age-related decline in physical and cognitive skills and stressed the importance of a healthy lifestyle. The ACS recommended that, starting at ages 65 to 70, surgeons undergo a voluntary and confidential baseline physician examination and visual testing for overall health assessment, with regular reevaluation thereafter. In addition, the ACS encouraged surgeons to voluntarily assess their neurocognitive function using confidential online tools and asserted a professional obligation to disclose any concerning findings, as well as inclusion of peer review reports in the re-credentialing process.⁴¹

1 The American College of Obstetricians and Gynecologists (ACOG) recommends that when
2 evaluating an aging physician, focus should be placed on the physician's quality of care provided
3 to patients.⁴² ACOG's recommendations regarding the later-career obstetrician–gynecologist also
4 state that: 1) it is important to establish systems-based competency assessments to monitor and
5 address physicians' health and the effect age has on performance and outcomes; 2) workplace
6 adaptations should be adopted to help obstetrician–gynecologists transition and age well in their
7 practice and throughout their careers; and 3) to avoid the potential for legal challenges, hospitals
8 should address the provisions of the Age Discrimination in Employment Act, making sure that
9 assessments are equitably applied to all physicians, regardless of age.⁴²

10
11 At Kaiser Permanente, within its Permanente Medical Group, physicians are classified as “in
12 partnership” or “incorporated.” In a region where a partnership exists, such as Southern California,
13 the mandatory retirement age as a partner is at the end of the calendar year when one turns 65.
14 Southern California Permanente Medical Group has approximately 3,000 partners, of which 300
15 retire each year at full retirement age. In the incorporated regions, there is no mandatory retirement
16 for clinicians. In the partnership regions, retired physicians (partners emeritus) may apply for
17 employment at age 66, but they are not guaranteed employment. If granted employment, these
18 physicians see a dramatic decrease in remuneration, and they are usually not required to have a
19 patient panel. Rehiring is at the discretion of the medical director and the budget. Therefore, a
20 limited number of opportunities are available. Approximately 10 percent of these physicians apply
21 for rehiring, and approximately 15 to 20 percent of those are rehired. They are usually limited to no
22 more than 20 hours per week performing either clinical or administrative work. As a result, very
23 few Permanente physicians work until age 70 or older.

24
25 The University of California, San Diego, Physician Assessment and Clinical Education (PACE)
26 Program is the largest assessment and remediation program for health care professionals in the
27 country. Recently, PACE conducted a pilot screening project to assess physicians. Thirty volunteer
28 physicians, aged 50 to 83, were recruited to participate in the screening regimen. Preliminary data
29 analysis showed that a number of senior physicians performed less than optimally (seven of 30
30 participants). However, when age-based capacity was reviewed (i.e., did those individuals between
31 50 to 59 or those between 60 to 69 years old perform better than those age 70 and older), the results
32 were not statistically significant. The pilot study did have sufficient power to reach significance.
33 However, the trend of the data was that older physicians did perform less optimally. It was also
34 noted that 75 percent of the physicians who didn't perform well on the MicroCog (a computerized
35 assessment that detects early signs of cognitive impairment) were still working in a clinical
36 capacity. The study did not include enough participants to provide a breakdown on specialties.

37 38 PROPOSED GUIDING PRINCIPLES

39
40 The Council on Medical Education proposes a set of guiding principles as a basis for developing
41 guidelines for the screening and assessment of senior/later career physicians. The underlying
42 assumption is that guidelines must be based on evidence and on the principles of medical ethics.
43 Furthermore, guidelines should be relevant, supportive, fair, equitable, and transparent, and not
44 result in undue cost or burden to senior physicians. The primary driver for the establishment of
45 guidelines should be to fulfill the ethical obligation of the profession to the health of the public and
46 patient safety.

47
48 The Council developed the following eight guiding principles with extensive feedback from
49 members of the AMA Work Group on Assessment of Senior/Late Career Physicians as well as
50 feedback from other content experts who research physician competence and administer screening
51 and assessment programs.

1. *Evidence-based:* The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Current research suggests that physician competency and practice performance decline with increasing years in practice. However, research also suggests that the effect of age on an individual physician's competency can be highly variable, and wide variations are seen in cognitive performance with aging.
2. *Ethical:* Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency.
3. *Relevant:* Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.
4. *Accountable:* The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.
5. *Fair and equitable:* The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians' practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. When public health or patient safety is directly threatened, removal from practice is one potential outcome.
6. *Transparent:* Guidelines, procedures, or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment.
7. *Supportive:* Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive.
8. *Cost conscious:* Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to senior physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed senior physicians. Similar procedures and screening mechanisms should be available to senior physicians who are not employed by hospitals and health care systems.

AMA POLICY

The AMA has policy in which it urges members of the profession to discover and rehabilitate if possible, or exclude if necessary, the physicians whose practices are incompetent, and to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, are in need of help or whose practices are incompetent (H-275.998). AMA policy urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions

that impair a physician's current ability to practice medicine (H-275.978[6]). AMA policy also reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and CME activities (H-300.973 and H-275.996). These and other related policies are attached (see Appendix).

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education concurs that physicians should be allowed to remain in practice as long as patient safety is not endangered, and they are providing appropriate and effective treatment. However, data and anecdotal information support the development of guidelines for the screening and assessment of senior/late career physicians. The variations around cognitive skills as physicians age, as well as the changing demographics of the physician workforce, are also key factors contributing to this need. It is critical that physicians take the lead in developing standards for monitoring and assessing their personal competency and that of fellow physicians to head off a call for nationally implemented mandatory retirement ages or imposition of guidelines by others. The guiding principles outlined in this report provide direction and serve as a reference for setting priorities and standards for further action.

The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed.

1. That our American Medical Association (AMA) make available to all interested parties the Assessment of Senior/Late Career Physicians Guiding Principles:
 - a) Evidence-based: The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Current research suggests that physician competency and practice performance decline with increasing years in practice. However, research also suggests that the effect of age on an individual physician's competency can be highly variable, and wide variations are seen in cognitive performance with aging.
 - b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency.
 - c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.
 - d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.
 - e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians' practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. When public health or patient safety is directly threatened, removal from practice is one potential outcome.
 - f) Transparent: Guidelines, procedures or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment.

- 1 g) Supportive: Education and/or remediation practices that result from screening and /or
- 2 assessment procedures should be supportive of physician wellness, ongoing, and proactive.
- 3 h) Cost conscious: Procedures and screening mechanisms that are distinctly different from
- 4 “for cause” assessments should not result in undue cost or burden to senior physicians
- 5 providing patient care. Hospitals and health care systems should provide easily accessible
- 6 screening assessments for their employed senior physicians. Similar procedures and
- 7 screening mechanisms should be available to senior physicians who are not employed by
- 8 hospitals and health care systems. (New HOD Policy)
- 9
- 10 2. That our AMA encourage the Federation of State Medical Boards, Council of Medical
- 11 Specialty Societies, and other interested organizations to develop educational materials on the
- 12 effects of age on physician practice for senior/late career physicians. (Directive to Take Action)
- 13
- 14 3. That Policy D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career
- 15 Physicians,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal note: \$1,000

APPENDIX: AMA POLICIES

D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians"

Our American Medical Association: (1) will identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior/late career physicians remain able to provide safe and effective care for patients; and (2) will convene organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings. (CME Rep. 5, A-15)

H-275.936, "Mechanisms to Measure Physician Competency"

Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency. (Res. 320, I-98 Amended: Res. 817, A-99 Reaffirmed: CME Rep. 7, A-02 Reaffirmed: CME Rep. 7, A-07 Reaffirmed: CME Rep. 16, A-09 Reaffirmed in lieu of Res. 313, A-12 Modified: Res. 309, I-16)

H-275.996, "Physician Competence"

Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 302, A-10; Reaffirmed in lieu of Res. 320, A-14)

H-275.998, "Physician Competence"

Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful. (4) State governments to provide to their state medical licensing boards resources

adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine. (5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent. (6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.) (CME Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03; Reaffirmed: CME Rep. 2, A-13)

H-275.978, "Medical Licensure"

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;

(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;

(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;

(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;

(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;

(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);

(7) urges licensing boards to maintain strict confidentiality of reported information;

(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;

(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;

(10) urges all physicians to participate in continuing medical education as a professional obligation;

(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;

(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;

(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;

(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;

(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;

(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;

(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;

(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;

(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;

(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;

(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and

(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.

(CME Rep. A, A-87 Modified: Sunset Report, I-97 Reaffirmation A-04 Reaffirmed: CME Rep. 3, A-10 Reaffirmation I-10 Reaffirmed: CME Rep. 6, A-12 Appended: Res. 305, A-13 Reaffirmed: BOT Rep. 3, I-14)

REFERENCES

1. AMA Physician Masterfile Data from 1975 to 2017. Chicago, IL. American Medical Association.
2. Soonsawat A, Tanaka G, Lammando MA, et al. Cognitively Impaired Physicians: How do we detect them? *Am J Geriatr Psychiatry*. 2018;26(6):631-640.
3. Hawkins RE, Welcher CM, Stagg Elliott, VS, et al. Ensuring Competent Care by Senior Physicians. *J Contin Educ Health Prof*. 2016;36(3):226-231.
4. Durning SJ, Artino AR, Holmboe E, et al. Aging and cognitive performance challenges and implications for physicians practicing in the 21st century. *J Contin Educ Health Prof*. 2010(Summer);30:153-160.
5. Moutier CY, Bazzo DEJ, Norcross WA. Approaching the Issue of the Aging Physician Population (Data from the Coalition for Physician Enhancement Conference). *Journal of Medical Regulation*. 2013;99(1):10-18.
6. Morrison J, Wickerhsam JS, MAppStat. Physicians disciplined by a state medical board. *JAMA*. 1998;279:1889-1893.
7. Kohatsu ND, Gould D, Ross LK, Fox PJ. Characteristics Associated with Physician Discipline. *Arch Int Med*. 2004;164:653-658.
8. Meeks TW, Jeste DV. Neurobiology of wisdom: A literature overview. *Arch Gen Psychiatry*. 2009;66:355-365.
9. Grossman I, Na J, et al. Reasoning about social conflicts improves into old age. *PNAS*. 2010;107:7246-7250.
10. Peisah C, et al. Secrets to psychological success: Why older doctors might have lower psychological stress. *Aging and Mental Health*. 2009;13:300-307.
11. Benbow SM, Jolly DJ. Burnout and stress amongst old age psychiatrists. *Int J Geriatr Psychiatry*. 2002;17:710-714.
12. Bazzo DEJ. Senior Physicians Section Educational Program. American Medical Association Annual House of Delegates Meeting. Chicago. June 7, 2014.
13. Miller SH. Coalition for Physician Enhancement Meeting. November 10-11, 2011.
14. Adler RG1, Constantinou C. Knowing - or not knowing - when to stop: cognitive decline in ageing doctors. *Med J Aust*. 2008 Dec 1-15;189(11-12):622-4.
15. Burroughs J. The aging physician: Balancing safety, respect, and dignity. Medical Staff Leader Insider, September 23, 2009. Available at: www.hcpro.com/MSL-239454-871/The-aging-physician-Balancing-safety-respect-and-dignity.html Accessed January 20, 2015.
16. Wynia MK. The Role of Professionalism and Self-regulation in Detecting Impaired or Incompetent Physicians. *JAMA*. 2010;304(2):210-211.
17. Dellinger EP, Pellegrini CA, Gallagher TH. The aging physician and the medical profession: A review. *JAMA Surgery*. 2017;152(10):967-971.
18. Heymann WR. Assessing the competence of aging physicians who are young at heart. *JAMA Dermatology*. 2018;
19. Campbell EG, Regan S, Gruen RI, et al. Professionalism in medicine; results of a national survey of physicians. *Ann Intern Med*. 2007;147:795-802.
20. DesRoches CM, Rao SR, Fromson JA, et al. Physicians' perceptions, preparedness for reporting, and experiences related to impaired and incompetent colleagues. *JAMA*. 2010;304:187-193.
21. LoboPrabhu SM, Molinari VA, Hamilton JD, Lomax JW. The Aging Physician With Cognitive Impairment: Approaches to Oversight. *Am J Geriatr Psychiatry*. 2009;17:445-454.
22. Lee HJ, Drag LL, Bieliauskas LA, et al. Results from the Cognitive Changes and Retirement among Senior Surgeons Self-Report Survey. *J Am Coll Surg*. 2009 Nov;209(5):668-671.
23. Moss AJ, Greenberg H, Dwyer EM, et al. Senior Academic Physicians and Retirement Considerations. *Prog Cardiovasc Dis*. 2013 May-Jun;55(6):611-5.

24. Levinson W, Ginsburg S. Is it time to retire? *JAMA*. 2017;317(15):1570-1571.
25. Wijeratne C, Peisah C. Accepting the challenges of ageing and retirement in ourselves: the need for psychiatrists to adopt a consensus approach. *Aust N Z J Psychiatry*. 2013 May;47(5):425-30.
26. Peisah C, Adler RG, Williams BW. Australian pathways and solutions for dealing with older impaired doctors: a prevention model. *Internal Medicine Journal*. 2007;37:826-831.
27. St George I, Kaigas T, McAvoy P. Assessing the Competence of Practicing Physicians in New Zealand, Canada, and the United Kingdom: Progress and Problems. *Fam Med*. 2004;36(3):172-7.
28. Shen L, Juul D, Faulkner LR. Performance of Certification and Recertification Examinees on Multiple Choice Text Items: Does Physician Age Have an Impact? *J Contin Educ Health Prof*. Spring 2016;36(2):119-122.
29. Hess BJ, Weng W, Holmboe ES, Lipner RS. The Association Between Physicians' Cognitive Skills and Quality of Diabetes Care. *Acad Med*. 2012 Feb;87(2):157-63.
30. Juul D, Vollmer J, Shen L, Faulkner LR. Comparison of Certification and Recertification Examinee Performance on Multiple-Choice Items in Forensic Psychiatry. *J AM Acad Psychiatry Law*. 2016;44(90):91-95.
31. Waxman BP. The Ageing Surgeon. *Med J Aust*. 2012; 196 (8): 498.
32. Royal Australasian College of Surgeons, Research & Evaluation, incorporating ASERNIP-S. Age, Performance and Revalidation Report. Available at: https://www.surgeons.org/media/25537510/rpt_2017-07-17_age_performance_and_revalidation.pdf Accessed August 15, 2018.
33. Eva KW. The Aging Physician: Changes in cognitive processing and their impact on medical practice. *Acad Med*. October 2002;77(10):S1-S6.
34. Blasier RB. The Problem of the Aging Surgeon: When Surgeon Age Becomes a Surgical Risk Factor. *Clin Orthop Relat Res*. 2009;467:402-411.
35. Bhatt NR, Morris M, O'Neil A, et al. When should surgeons retire? *Br J Surg*. 2016;103:35-43.
36. Godlee F. We need to separate "old" and "age." *BMJ*. 2013;347:f6823.
37. Jessop JR. We need to get another life after retirement. *BMJ*. 2013;347:7173.
38. Racine M. Should older family physicians retire? Yes. *Can Fam Physician*. 2012 Jan;58(1):22, 24.
39. Lee L, Weston W. The Aging Physician. *Can Fam Physician*. 2012;58(1):17-8.
40. Richards R, McLeod R, Latter D, et al. Toward late career transitioning: a proposal for academic surgeons. *Can J Surg*. 2017;60(5):355-358.
41. American College of Surgeons Board of Governors Physician Competency and Health Workgroup: Statement on the Aging Surgeon. January 1, 2016. Available at: <https://www.facs.org/about-ac/s/statements/80-aging-surgeon> Accessed July 11, 2018.
42. The Late-Career Obstetrician-Gynecologist. The American College of Obstetricians and Gynecologists. June 2018. Available at: <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/The-Late-Career-Obstetrician-Gynecologist> Accessed August 15, 2018.

REPORT 3 OF THE COUNCIL ON MEDICAL EDUCATION (I-18)
Developing Physician-Led Public Health/Population Health Capacity in Rural Communities
(Reference Committee C)

EXECUTIVE SUMMARY

American Medical Association (AMA) Policy D-295.311, “Developing Physician Led Public Health/Population Health Capacity in Rural Communities,” asks that our AMA, with the participation of the appropriate educational and certifying entities, study innovative approaches that could be developed and/or implemented to support interested physicians as they seek qualifications and credentials in preventive medicine/public health to strengthen public health leadership, especially in rural communities.

Our country’s need for public health and preventive medicine investments continues to grow, spurred by many factors (e.g., the closing of rural hospitals, lack of access to urban health care, maintaining the viability of safety-net hospitals, the opioid crisis, increasing prevalence of lifestyle diseases, etc.), and resource deficiencies have been documented in both rural and urban communities. It is well documented that investments in preventive medicine and public health are cost effective and save lives. Therefore, support for physicians seeking qualifications and credentials in these areas is desirable.

A wide range of organizations, both physician- and non-physician focused, offers education and resources regarding this important topic. Rural training tracks and programs are available at the UME, GME, and postgraduate level, and multiple national public/population health organizations offer strategies and solutions to individuals and entities seeking to improve their public health knowledge and gain new skills. The AMA also offers resources that help physicians expand their knowledge base in population/public health, including STEPSforward™ modules and the Health Systems Science textbook, which focuses on providing a fundamental understanding of how health care is delivered, how health care professionals work together to deliver that care, and how the health system can improve patient care and health care delivery. Programs are also available to address the multiple complex issues related to the advancement of women’s health and fulfilling women’s potential for leadership in education, research, and clinical practice.

This report focuses on existing and planned educational interventions that are intended to help physicians and medical students develop professional skills and qualifications related to preventive, public, population, and rural health. The report: 1) outlines previous Council on Medical Education reports related to this topic; 2) summarizes relevant available resources; and 3) makes recommendations to the House of Delegates.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-I-18

Subject: Developing Physician-Led Public Health/Population Health Capacity in Rural Communities

Presented by: Carol Berkowitz, MD, Chair

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

INTRODUCTION

American Medical Association (AMA) Policy D-295.311, “Developing Physician Led Public Health/Population Health Capacity in Rural Communities,” asks that our AMA, with the participation of the appropriate educational and certifying entities, study innovative approaches that could be developed and/or implemented to support interested physicians as they seek qualifications and credentials in preventive medicine/public health to strengthen public health leadership, especially in rural communities. Previous reports on this topic include Council on Medical Education Report 11-A-09, “Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum”; Council on Medical Education Report 8-A-08, “One-Year Public Health Training Options for All Specialties”; and Council on Medical Education Report 12-A-07, “One-Year Public Health Training Options for All Specialties.”

This report focuses on existing and planned educational interventions that are intended to help physicians and medical students develop professional skills and qualifications related to preventive, public, population, and rural health. The report: 1) outlines previous Council on Medical Education reports related to this topic; 2) summarizes relevant available resources; and 3) makes recommendations to the HOD.

BACKGROUND

Our country’s need for public health and preventive medicine investments continues to grow, spurred by a number of factors (e.g., the closing of rural hospitals, lack of access to urban health care, maintaining the viability of safety-net hospitals, the opioid crisis, and the increasing prevalence of lifestyle diseases), and resource deficiencies have been documented in both rural and urban communities.^{1,2,3,4} The Affordable Care Act (ACA) reduced the number of uninsured persons due to Medicaid expansion, health insurance marketplaces, the employer mandate to provide health insurance, and a provision permitting young adults to remain on a parent’s health insurance plan until 26 years of age. However, an estimated 27 million U.S. citizens remain uninsured.⁵ Inpatient, emergency, and ambulatory services for this population, as well as for millions of other patients, particularly Medicaid beneficiaries, continue to rely on safety-net health systems that provide health care regardless of the patient’s ability to pay. Although a few programs, such as Emergency Medicaid, provide some payment for lifesaving treatments and limited recovery services, longer-term care, such as psychiatric care, is also disproportionately delivered by safety-net health systems.⁵

In 2017, Congress eliminated the individual mandate penalty for not having health insurance (effective 2019);⁴ this will have the greatest effect on safety net hospitals that are already in poor financial condition, especially those in rural and suburban areas. Without the mandate, more people are likely to forgo insurance and, if they later need care, will seek that care from safety-net health systems. Since the total demand for uncompensated care in a health care market does not change, evidence suggests that there is nearly complete spillover of uncompensated care to neighboring hospitals.⁵

It is well documented that investments in preventive medicine and public health are cost effective and save lives.^{6,7,8,9} Therefore, support for physicians seeking qualifications and credentials in these areas is desirable.

The AMA Council on Medical Education (CME) has addressed related topics on several previous occasions.

CME Report 11-A-09, “Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum,” identified ways in which medical students are educated in public health and reported on strategies for integrating public health-related content across the medical education continuum. The report further recommends that our AMA encourage medical schools, schools of public health, graduate medical education programs, and key stakeholder organizations to develop and implement longitudinal educational experiences in public health for medical students in the pre-clinical and clinical years and to provide both didactic and practice-based experiences in public health for residents in all specialties including public health and preventive medicine; and that our AMA encourage the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.

CME Reports 8-A-08 and 12-A-07, both titled “One-Year Public Health Training Options for All Specialties,” concluded that a strong public health infrastructure is necessary to further advancements that have been made in public health as well as to combat existing and future threats to the nation’s health. Further, these reports noted that concern over the nation’s ability to produce the number of well-trained public health physicians needed to address these public health needs has been growing, and that there is clear need for a cadre of physicians prepared for public health practice.

CME Report 4-A-10, “Educational Strategies to Promote Physician Practice in Underserved Areas,” does not specifically address public or population health. However, it does link the importance of exposure to rural training experiences to eventual rural practice.

DISCUSSION

A wide range of organizations, both physician- and non-physician-focused, offers education and resources regarding this important topic.

American Board of Preventive Medicine

The American Board of Preventive Medicine (ABPM) offers four pathways to achieve board certification in Public Health and General Preventive Medicine.

- Residency Pathway

The ABPM Residency Pathway is open to all individuals “who have completed an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency of not less than two years, in the specialty area for which certification is being sought.”¹⁰ Participation in the pathway requires a supervised year of postgraduate clinical training, including at least 10 months of direct patient care; completion of an ACGME-accredited residency training program accredited in the specialty area for which certification is being pursued; successful completion of an MPH or equivalent graduate degree; and demonstration of current practice if more than 24 months have passed since completion of residency training (unless otherwise engaged in specialty or subspecialty training).

- Complementary Pathway

The ABPM Complementary Pathway, meant to engage mid-career physicians seeking to change their specialty practice, requires two years of supervised postgraduate clinical training in an ACGME-accredited training program; a year of ACGME-accredited residency training in the specialty area in which certification is sought; postgraduate level coursework in epidemiology, biostatistics, health services administration, environmental health sciences, and social and behavioral health sciences; and proof of current practice (unless in training) for two of the last five years.

- Special Pathway

The ABPM Special Pathway allows ABPM diplomates with current certification in Aerospace Medicine, Occupational Medicine, or Public Health and General Preventive Medicine to pursue certification in another ABPM primary specialty. (Diplomates with current subspecialty certification in Addiction Medicine, Clinical Informatics, Medical Toxicology, and Undersea and Hyperbaric Medicine are not eligible for this pathway.) In addition to ABPM specialty certification, candidates must also be able to demonstrate they have been practicing (or training) for two of the last five years in the specialty/subspecialty area in which they are seeking additional certification.

- Alternative Pathway

The ABPM Alternative Pathway is only applicable to those individuals who graduated from medical school prior to January 1, 1984, and who do not qualify for certification through one of the three previously described pathways. In addition to the graduation year requirement, candidates must have completed a year of supervised postgraduate training in an ACGME-accredited GME program, including at least 10 months of direct patient care; postgraduate level coursework in epidemiology, health services administration, environmental health sciences, and social and behavioral health sciences; and demonstration of practice for at least two of the last five years. For this category, the required, demonstrated number of years in practice is dependent on ABMS member board certification status; completion of residency training in the specialty area in which certification is sought; and possession of an MPH degree or equivalent.

American College of Physicians

The American College of Physicians (ACP) sponsors an ACP Leadership Academy, which provides leadership training and resources.¹¹ The Academy offers an 18-month certificate program in conjunction with the American Association for Physician Leadership, including a combination of formal training (through webinar or live coursework), group discussions, and a capstone project. The Leadership Academy also offers free webinars,¹² several of which (population health, leadership principles for women in medicine) are directly related to this report.

1 Recently, the ACP released a position paper noting that, “The American College of Physicians
 2 recommends that social determinants of health and the underlying individual, community, and
 3 systemic issues related to health inequities be integrated into medical education at all levels.”¹³ The
 4 paper also reviews particular health challenges associated with rural locations.

5
 6 *Efforts of the Accelerating Change in Medical Education Consortium*
 7

8 Many Accelerating Change in Medical Education Consortium members have been working to
 9 address population, public, and rural health education at the UME level.¹⁴

- 10
- 11 • The partnership between A.T. Still University’s School of Osteopathic Medicine in
- 12 Arizona and the National Association of Community Health Centers embeds second-,
- 13 third-, and fourth-year medical students in rural health centers. Additionally, second-year
- 14 students participate in a year-long course in epidemiology, biostatistics, and preventive
- 15 medicine, during which they work with community stakeholders and health centers to
- 16 identify and address local issues of community concern.
- 17 • The Brody School of Medicine at East Carolina University integrates a population health
- 18 component into its comprehensive longitudinal core curriculum.
- 19 • Case Western Reserve University School of Medicine incorporates a patient navigator
- 20 model into its curriculum, and medical student navigators learn to use and create registries
- 21 for population health management in specific population groups.
- 22 • The curriculum at Dell Medical School at the University of Texas at Austin is built around
- 23 instruction in leadership, which is incorporated into all four years of education. During the
- 24 third year, students can choose to focus on specific areas of study, including population
- 25 health.
- 26 • Upon joining the consortium, Florida International University Herbert Wertheim College
- 27 of Medicine enhanced its “Green Family Foundation Neighborhood Health Education
- 28 Learning Program” (NeighborhoodHELP™), which provides a longitudinal,
- 29 interprofessional community-based experience for medical students and partnerships with
- 30 local hospitals.
- 31 • The blended learning curriculum at the Mayo Clinic School of Medicine focuses on six
- 32 content domains, one of which is population-centered care. Students can also pursue an
- 33 additional 12 credits to receive a master’s degree in health care delivery science, which
- 34 includes instruction in population and preventive health. Further, Mayo has created
- 35 milestones for students related to population health in alignment with ACGME
- 36 competencies.
- 37 • The New York University School of Medicine’s Health Care by the Numbers curriculum
- 38 uses very large de-identified datasets to train students to improve the health of populations.
- 39 • Ohio University Heritage College of Osteopathic Medicine integrates population health
- 40 into its continuous, longitudinal curriculum.
- 41 • The University of Connecticut School of Medicine’s MDelta curriculum has been
- 42 specifically designed so that all students can achieve a certificate in public health, with a
- 43 specific focus on disparities and the social determinants of health. Additionally, the school
- 44 has incorporated the Regenstrief EHR Clinical Learning Platform into the MDelta
- 45 curriculum. This platform includes large numbers of de-identified patient records, allowing
- 46 students to research population health issues.
- 47 • The University of Nebraska Medical Center College of Medicine, through its focus on
- 48 interprofessional education, has established official partnerships with its colleges of
- 49 nursing, public health, pharmacy, dentistry, and allied health professions.
- 50 • The University of North Dakota School of Medicine and Health Sciences incorporates
- 51 training in the use of telemedicine to connect remote patients and providers at multiple

locations to address rural health care needs. Simulation training mimics common cases seen in rural settings.

- Medical students at the University of Texas Rio Grande Valley School of Medicine learn onsite in unincorporated *colonias* along the U.S./Mexico border, allowing incorporation of oral histories into the medical record. Students also have the opportunity to shadow community health workers, or *promotoras*, as part of a curriculum that simulates the process necessary to convince legislators to fund similar interventions.
- In Vanderbilt University School of Medicine's longitudinal, four-year Foundations of Health Care Delivery course, third- and fourth-year medical students complete self-directed modules in a number of topic areas, including advanced population health and public health.
- The Warren Alpert Medical School of Brown University offers nine courses in its Master of Science degree in population medicine, covering social determinants of health, disparities, instruction in population medicine research, leadership, and epidemiology. Some of these courses are required for all students, even if not pursuing the master's degree. Students are also required to prepare a thesis on population medicine.

Combined UME, GME, and Postgraduate Educational Programs and Rural and Public/Population Health Training Tracks

The topic of public/population health recently has been the focus of increased attention and study for physician learners,^{15, 16} and a number of public health training opportunities are available to learners beginning at the UME level. According to the Association of American Medical Colleges (AAMC), 87 MD-MPH programs are currently offered at institutions spanning 37 states and the District of Colombia.¹⁷ The American Association of Colleges of Osteopathic Medicine (AACOM) also maintains a list of dual degree programs. As of June 2018, 17 institutions offered combined DO-MPH degrees.¹⁸

In addition to MD- or DO-MPH programs, some medical schools offer specific experiences in rural training. For example, the Rural Opportunities in Medical Education (ROME) program at the University of North Dakota School of Medicine is available to third-year students and involves a multi-month, interdisciplinary assignment to a rural primary care setting.¹⁹ Likewise, the Wisconsin Academy for Rural Medicine (WARM) is a training program intended to address rural physician shortages and ultimately improve the health of rural Wisconsin.²⁰ Of WARM graduates, 91 percent practice in Wisconsin, and 52 percent practice primary care medicine. Similar to the ROME program, the Rural Physician Associate Program (RPAP) offered by the University of Minnesota Medical School provides third-year medical students a hands-on opportunity to live and train in rural communities.²¹

Due to limited access to health care in some regions of West Virginia, the Rural Health Partners Scholarship Program is collaborating with third-year medical students who are interested in matching into a Charleston Area Medical Center (CAMC) Residency Program.²² Scholarship recipients receive mentoring during their fourth year of medical school in preparation for the residency program; experience a one-month rural health rotation at one of the participating rural sites; complete a required research project; and then receive a \$10,000 scholarship when they successfully graduate from medical school and match into one of the participating CAMC residency programs. The candidates must be medical students at West Virginia University, Marshall University, or West Virginia School of Osteopathic Medicine. The educational base and residency enable students to develop clinical and leadership experiences uniquely targeted for rural and underserved areas.²⁰ (The "All-in Policy" for waivers from the National Resident Matching Program is currently under review. Certain CAMC departments such as family medicine may

pursue and be awarded such a match waiver. Applicants will be notified of waiver status as that information becomes available.)²⁰

At the GME level, the ACGME Common Program Requirements include expectations that issues related to public health be included in the educational program for all specialties. Among the ACGME's six competencies, Systems-Based Practice is especially relevant to the integration of public health. This competency states that "Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care." This includes "advocating for quality patient care and optimal patient care systems...incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate," and "understanding health care finances and its impact on individual patients' health decisions."²³

Several individual specialties also incorporate training in public health-related matters. Accreditation requirements for pediatrics, for example, require structured activities designed to prepare pediatric residents to be effective advocates for the health of children in the community. Additionally, many family medicine residencies teach community-oriented primary care, which integrates public health principles into primary care practice.

Combined residency programs also are available for trainees interested in pursuing experience in public/population health. Of the 73 currently accredited residency training programs in preventive medicine,²⁴ three are combined family medicine/preventive medicine programs, and six are combined internal medicine/preventive medicine programs.²⁵ Furthermore, of the 11,300 ACGME-accredited programs in all specialties, 357 indicated that they offer a separate rural track.²⁶

For example, Texas Tech University has established a rural health residency training program in family medicine at four sites (Andrews, Fort Stockton, Sweetwater, and Alpine). The program began as a 1115 waiver project/grant of \$3 million and has been successful enough that each of the hospitals involved is now contributing funding to support the program. The program requires residents to complete a one-year core program and then two years of training at a rural site in West Texas. The goal is to place physicians in the region who will stay and provide care to the residents of these locations. Texas currently has the largest number of at-risk hospitals of any state in the nation (75).²⁷

For medical school graduates, public/population health training opportunities exist beyond combined residency training programs. The AAMC curates a list of public health pathways.²⁸ Currently, the website identifies 57 public health fellowship, faculty development, and continuing education opportunities.

At the postgraduate level, the Centers for Disease Control and Prevention (CDC), through its Epidemic Intelligence Service (EIS) Program, offers two-year, postgraduate programs that train physicians (and others) in infectious disease investigation, thereby preparing them to respond to public health threats both domestically and internationally. In 2017, 71 EIS officers were trained through this program, 65 of whom were U.S. citizens or permanent residents.²⁹

National Public Health Organizations

Multiple national public/population health organizations currently offer strategies and solutions to individuals and entities seeking to improve their public health knowledge and gain new skills.

- 1 • The American Association of Public Health Physicians (AAPHP), founded to provide a
2 voice to physician directors of state and local health departments at the national level,
3 offers publicly available educational resources, ranging from ethics in public health, food
4 safety, fracking, and gun violence/racism prevention.³⁰
5
- 6 • In addition to a collection of reports, educational webinars, and policy statements on a
7 broad range of public health topics, the American Public Health Association offers a
8 substantial number of internships (not limited to physicians-in-training or physicians) in
9 topics ranging from environmental health, government relations, injury and violence
10 prevention, and public health policy, as well as a Public Health Fellowship in Government.
11 This fellowship places future public health leaders into positions as staff members for
12 elected officials in Congress.³¹
13
- 14 • The National Association of County and City Health Officials (NACCHO) offers a
15 publicly available “toolbox” focusing on public health tools created by and for members of
16 the public health community. Tools range from emergency preparedness and vector control
17 to public engagement and injury and violence prevention. NACCHO also offers a library
18 of best practices related to chronic disease management intended to help local health
19 departments stay current in both knowledge and interventions.³² Furthermore, NACCHO
20 University is an online learning hub where public health professionals can access training
21 and develop competencies.³³ Finally, NACCHO Consulting works with local public health
22 departments on research and evaluation projects, performance improvement, workforce
23 development, and public health topics.³⁴
24
- 25 • The CDC has compiled a resource list “for health professional students, educators, and
26 health professionals to learn more about issues affecting individuals at a population level,
27 to become more familiar with other population health issues, to integrate public health into
28 existing curricula, and for increased collaboration with public health.”³⁵ This list comprises
29 collaborative efforts, competencies, curricula, training opportunities, and peer-reviewed
30 publications, among other resources.
31
- 32 • The Public Health Leadership Forum, funded by the Robert Wood Johnson Foundation,
33 seeks to engage public health leaders and stakeholders in efforts that promote
34 transformation in the field of public health.³⁶ The Forum has worked on a number of
35 impactful projects, including the development of a set of foundational public health
36 services for public health departments and the visioning of the future of high-functioning
37 public health departments.
38
- 39 • The Association of State and Territorial Health Officials (ASTHO) has developed a list of
40 educational tools and resources that support cooperation between public health and primary
41 care organizations.³⁷ ASTHO also provides resources to state and territorial health officials
42 regarding proven and cost-effective population health improvement approaches.³⁸
43
- 44 • The National Network of Public Health Institutes serves as the national coordinating center
45 for ten regional public health training centers and 40 additional local sites to “offer high-
46 quality training, tools, and resources for thousands of professionals engaged in the critical
47 work of advancing public health practice and improving population health,”³⁹ and serves as
48 facilitator of the Public Health Learning Network. These training centers and affiliate sites
49 focus on building skills in change management, communication, diversity/inclusion,
50 information/analytics, leadership, policy engagement, problem solving, resource

management, and systems thinking on a wide range of topics in communities across the United States.

- In conjunction with other organizations, the Council of State and Territorial Epidemiologists currently sponsors four fellowships in applied epidemiology, public health informatics, health systems integration, and informatics (training in place).⁴⁰ Fellowship recipients commit to two years of on-the job training onsite at a state or local health agency, in step with recommendations from the National Academy of Medicine (NAM) that “State and large local health departments, in conjunction with medical schools and schools of public health, expand postresidency fellowships in public health that emphasize transition into governmental public health practice.”⁴¹
- Also supportive of this NAM recommendation are fellowships sponsored by the Association of Schools and Programs of Public Health (ASPPH). ASPPH notes that more than 2,200 “ASPPH Fellows and Interns have been placed at state/local health departments and federal agency offices across the U.S., and in 26 countries worldwide where U.S. agencies are assisting Ministries of Health.”⁴²

Additional AMA Resources

The AMA’s STEPS ForwardTM library includes a module on Project ECHOTM, which is specifically designed to help coordinate care across rural areas in need of certain specialty care.⁴³ Additionally, the AMA published a STEPS ForwardTM module on social determinants of health in September 2018.⁴⁴

Further, the AMA’s groundbreaking work in the discipline of health systems science (HSS) has highlighted the importance of teaching physician learners how to advocate for their patients and communities and understand the socioecological determinants of health, health care policy, and health care economics. The AMA’s HSS textbook⁴⁵ is the first text that focuses on providing a fundamental understanding of how health care is delivered, how health care professionals work together to deliver that care, and how the health system can improve patient care and health care delivery. Along with the basic and clinical sciences, HSS is rapidly becoming a crucial “third pillar” of medical science, requiring a practical, standardized curriculum with an emphasis on understanding the role of human factors, systems engineering, leadership, and patient improvement strategies that will help transform the future of health care and ensure greater patient safety. As of the writing of this report, the AMA’s HSS textbook is in use by 32 medical schools across the country, and a second edition is scheduled to be released at the end of 2019.

PROMOTING PUBLIC HEALTH LEADERSHIP

A review of the medical education literature finds recommendations for strategies to improve the development of public health leadership capacity across the medical education continuum. Such strategies include instituting specific public health leadership curricula;⁴⁶ looking at how public health leadership is currently defined;⁴⁷ focusing on the specific skills and talents public health leaders require;⁴⁸ and considering the risks and benefits of engaging non-clinician celebrity diplomacy.⁴⁹

Additional studies focus more specifically on the limits of public health leadership programs. Grimm et al. note that the number of public health leadership programs has declined since 2012 and consequently proposed a framework for greater uniformity in leadership development and evaluation.⁵⁰ Others note that evaluation of public health leadership interventions is often lacking.⁵¹

Leadership Roles for Women

Although their numbers in leadership roles are increasing, women remain underrepresented in the top echelons of health care leadership, and gender differences exist in the types of leadership roles women do attain.⁵² The Department of Health and Human Services Office on Women's Health, through its National Center of Excellence initiative, has encouraged the institutions participating in the initiative to address the multiple complex issues that are impeding the advancement of women in education, research, and clinical practice and are preventing the realization of women physicians' full potential for leadership.⁵³

Considering the many ways that sex and gender influence disease presentation and patient management, there have been various studies and initiatives to improve the integration of these topics into medical education. A growing network of medical and academic institutions, professional organizations, government agencies, and individuals who share a vision of women's health and sex- and gender-specific medicine are developing materials for medical education and clinical practice. The Laura W. Bush Institute for Women's Health and the Texas Tech University Medical Center Women's Health Committee have developed a website that provides resources on sex- and gender-specific health and continuing medical education programs. The Sex and Gender Women's Health Collaborative maintains a digital resource library of sex- and gender-specific materials. The Office of Research on Women's Health website offers a series of courses for researchers, clinicians, and students to provide a foundation for sex and gender accountability in medical research and treatment. Articles that present a case for the inclusion of sex- and gender-focused content into medical education curricula are summarized in a [bibliography](#) that was recently developed for the AMA Council on Medical Education website.

Programs are also available to educate women on the practices needed to enhance their leadership skills and effectiveness. One example is the Emerging Women Executives in Health Care Program, offered through the Harvard T.H. Chan School of Public Health.⁵⁴

RELEVANT AMA POLICY

The AMA has extensive policy related to this topic; these policies are listed in the Appendix.

SUMMARY AND RECOMMENDATIONS

Leadership in public and population health remains an important topic deserving of continued interest within the community of medicine. In addition to the ongoing focus on available training opportunities related to public/population health leadership for physicians and medical students, attention should be directed to the future composition of the country's public health leaders. A recent study found that 73 percent of deans of schools of public health were male, and 70 percent received their terminal degree more than 35 years ago; 64 percent of state health directors received their terminal degree more than 25 years ago; and 26 percent of state health directors hold no terminal degree.¹⁴ There is no evidence to suggest that these individuals are anything other than effective, dedicated leaders who are passionate about promoting public/population health in their communities and throughout the country. However, these statistics should perhaps spark a discussion within the medical community regarding how individuals are currently encouraged and incentivized to enter public health leadership positions, and how to ensure that current public/population health leaders are actively engaging in relevant lifelong learning.

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

- 1 1. That Policy D-295.311, “Developing Physician Led Public Health / Population Health
2 Capacity in Rural Communities,” be rescinded, as having been fulfilled by this report.
3 (Rescind HOD Policy)
4
- 5 2. That our American Medical Association (AMA) reaffirm the following policies:
6 D-295.327, “Integrating Content Related to Public Health and Preventive Medicine Across
7 the Medical Education Continuum”
8 D-305.964, “Support for the Epidemic Intelligence Service (EIS) Program and Preventive
9 Medicine Residency Expansion”
10 D-305.974, “Funding for Preventive Medicine Residencies”
11 H-425.982, “Training in the Principles of Population-Based Medicine”
12 D-440.951, “One-Year Public Health Training Options for all Specialties”
13 H-440.954, “Revitalization of Local Public Health Units for the Nation”
14 H-440.888, “Public Health Leadership”
15 H-440.969, “Meeting Public Health Care Needs Through Health Professions Education”
16 (Reaffirm HOD Policy)
17
- 18 3. That our AMA encourage the Association of American Medical Colleges (AAMC),
19 American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation
20 Council for Graduate Medical Education (ACGME) to highlight public/population health
21 leadership learning opportunities to all learners, but especially to women and those who are
22 underrepresented in medicine. (Directive to Take Action)
23
- 24 4. That our AMA encourage public health leadership programs to evaluate the effectiveness
25 of various leadership interventions. (Directive to Take Action)

Fiscal Note: \$1,000.

APPENDIX: RELEVANT AMA POLICY

8.11, "Health Promotion and Preventive Care"

Medicine and public health share an ethical foundation stemming from the essential and direct role that health plays in human flourishing. While a physician's role tends to focus on diagnosing and treating illness once it occurs, physicians also have a professional commitment to prevent disease and promote health and well-being for their patients and the community.

The clinical encounter provides an opportunity for the physician to engage the patient in the process of health promotion. Effective elements of this process may include educating and motivating patients regarding healthy lifestyle, helping patients by assessing their needs, preferences, and readiness for change and recommending appropriate preventive care measures. Implementing effective health promotion practices is consistent with physicians' duties to patients and also with their responsibilities as stewards of health care resources.

While primary care physicians are typically the patient's main source for health promotion and disease prevention, specialists can play an important role, particularly when the specialist has a close or long-standing relationship with the patient or when recommended action is particularly relevant for the condition that the specialist is treating. Additionally, while all physicians must balance a commitment to individual patients with the health of the public, physicians who work solely or primarily in a public health capacity should uphold accepted standards of medical professionalism by implementing policies that appropriately balance individual liberties with the social goals of public health policies.

Health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients' self-directed roles and responsibilities in maintaining health. In keeping with their professional commitment to the health of patients and the public, physicians should:

- (a) Keep current with preventive care guidelines that apply to their patients and ensure that the interventions they recommend are well supported by the best available evidence.
- (b) Educate patients about relevant modifiable risk factors.
- (c) Recommend and encourage patients to have appropriate vaccinations and screenings.
- (d) Encourage an open dialogue regarding circumstances that may make it difficult to manage chronic conditions or maintain a healthy lifestyle, such as transportation, work and home environments, and social support systems.
- (e) Collaborate with the patient to develop recommendations that are most likely to be effective.
- (f) When appropriate, delegate health promotion activities to other professionals or other resources available in the community who can help counsel and educate patients.
- (g) Consider the health of the community when treating their own patients and identify and notify public health authorities if and when they notice patterns in patient health that may indicate a health risk for others.
- (h) Recognize that modeling health behaviors can help patients make changes in their own lives.

Collectively, physicians should:

- (i) Promote training in health promotion and disease prevention during medical school, residency and in continuing medical education.
- (j) Advocate for healthier schools, workplaces and communities.
- (k) Create or promote healthier work and training environments for physicians.
- (l) Advocate for community resources designed to promote health and provide access to preventive services.
- (m) Support research to improve the evidence for disease prevention and health promotion.

H-225.949, "Medical Staff and Hospital Engagement of Community Physicians"

2. Our AMA encourages medical staffs and hospitals to engage community physicians, as appropriate, in medical staff and hospital activities, which may include but need not be limited to: (a) medical staff duties and leadership; (b) hospital governance; (c) population health management initiatives; (d) transitions of care initiatives; and (e) educational and other professional and collegial events.

D-295.327, "Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum"

1. Our AMA encourages medical schools, schools of public health, graduate medical education programs, and key stakeholder organizations to develop and implement longitudinal educational experiences in public health for medical students in the pre-clinical and clinical years and to provide both didactic and practice-based experiences in public health for residents in all specialties including public health and preventive medicine.
2. Our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.
3. Our AMA actively encourages the development of innovative models to integrate public health content across undergraduate, graduate, and continuing medical education.
4. Our AMA, through the Initiative to Transform Medical Education (ITME), will work to share effective models of integrated public health content.
5. Our AMA supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents.
6. Our AMA will urge the Centers for Medicare and Medicaid Services to include resident education in public health graduate medical education funding in the Medicare Program and encourage other public and private funding for graduate medical education in prevention and public health for all specialties

H-295.868, "Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training"

1. Our AMA recommends that formal education and training in disaster medicine and public health preparedness be incorporated into the curriculum at all medical schools and residency programs.
2. Our AMA encourages medical schools and residency programs to utilize multiple methods, including simulation, disaster drills, interprofessional team-based learning, and other interactive formats for teaching disaster medicine and public health preparedness.
3. Our AMA encourages public and private funders to support the development and implementation of education and training opportunities in disaster medicine and public health preparedness for medical students and resident physicians.
4. Our AMA supports the National Disaster Life Support (NDLS) Program Office's work to revise and enhance the NDLS courses and supporting course materials, in both didactic and electronic formats, for use in medical schools and residency programs.
5. Our AMA encourages involvement of the National Disaster Life Support Education Consortium's adoption of training and education standards and guidelines established by the newly created Federal Education and Training Interagency Group (FETIG).
6. Our AMA will continue to work with other specialties and stakeholders to coordinate and encourage provision of disaster preparedness education and training in medical schools and in graduate and continuing medical education.

7. Our AMA encourages all medical specialties, in collaboration with the National Disaster Life Support Educational Consortium (NDLSEC), to develop interdisciplinary and inter-professional training venues and curricula, including essential elements for national disaster preparedness for use by medical schools and residency programs to prepare physicians and other health professionals to respond in coordinated teams using the tools available to effectively manage disasters and public health emergencies.
8. Our AMA encourages medical schools and residency programs to use community-based disaster training and drills as appropriate to the region and community they serve as opportunities for medical students and residents to develop team skills outside the usual venues of teaching hospitals, ambulatory clinics, and physician offices.
9. Our AMA will make medical students and residents aware of the context (including relevant legal issues) in which they could serve with appropriate training, credentialing, and supervision during a national disaster or emergency, e.g., non-governmental organizations, American Red Cross, Medical Reserve Corps, and other entities that could provide requisite supervision.
10. Our AMA will work with the Federation of State Medical Boards to encourage state licensing authorities to include medical students and residents who are properly trained and credentialed to be able to participate under appropriate supervision in a national disaster or emergency.
11. Our AMA encourages physicians, residents, and medical students to participate in disaster response activities through organized groups, such as the Medical Response Corps and American Red Cross, and not as spontaneous volunteers.
12. Our AMA encourages teaching hospitals to develop and maintain a relocation plan to ensure that educational activities for faculty, medical students, and residents can be continued in times of national disaster and emergency.

D-305.964, "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion"

Our AMA will work to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program and work to support increased federal funding for preventive medicine residency training programs.

D-305.974, "Funding for Preventive Medicine Residencies"

Our AMA will work with the American College of Preventive Medicine, other preventive medicine specialty societies, and other allied partners, to formally support legislative efforts to fund preventive medicine training programs.

D-385.963, "Health Care Reform Physician Payment Models"

8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.
9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.
10. Our AMA encourages state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.

H-425.982, "Training in the Principles of Population-Based Medicine"

The AMA will continue to monitor and support the progress made by medical and public health organizations in championing disease prevention and health promotion; and will support efforts to bring schools of medicine and public health back into a closer relationship.

H-425.984, "Clinical Preventive Services"

Implications for Adolescent, Adult, and Geriatric Medicine: (1) Prevention should be a philosophy that is espoused and practiced as early as possible in undergraduate medical schools, residency training, and continuing medical education, with heightened emphasis on the theory, value, and implementation of both clinical preventive services and population-based preventive medicine. (2) Practicing physicians should become familiar with authoritative clinical preventive services guidelines and routinely implement them as appropriate to the age, gender, and individual risk/environmental factors applicable to the patients in the practice at every opportunity, including episodic/acute care visits. (3) Where appropriate, clinical preventive services recommendations should be based on outcomes-based research and effectiveness data. Federal and private funding should be increased for further investigations into outcomes, application, and public policy aspects of clinical preventive services.

H-425.986, "Challenges in Preventive Medicine"

It is the policy of the AMA that (1) physicians should become familiar with and increase their utilization of clinical preventive services protocols; (2) individual physicians as well as organized medicine at all levels should increase communication and cooperation with and support of public health agencies. Physician leadership in advocating for a strong public health infrastructure is particularly important; (3) physicians should promote and offer to serve on local and state advisory boards; and (4) in concert with other groups, physicians should study local community needs, define appropriate public health objectives, and work toward achieving public health goals for the community.

H-425.993, "Health Promotion and Disease Prevention"

The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; and (5) strongly emphasizes the important opportunity for savings in health care expenditures through prevention.

H-440.888, "Public Health Leadership"

Our AMA: (1) urges that appropriately trained and experienced licensed physicians (MDs or DOs) be employed by state and local health departments to be the responsible leader when patient care decisions are made, whether for individuals in the STD or TB Clinics or for the community at large when an epidemic is to be managed; and

(2) defines public health leadership and decision-making that promotes health and prevents disease in the community as the practice of medicine, requiring a licensed practitioner with all the skills, training, experience and knowledge of a public health trained physician.

H-440.892, "Bolstering Public Health Preparedness"

Our AMA supports: (1) the concept that enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be specifically targeted as among our nation's highest priorities; and (2) in principle, the funding of research into the determinants of quality performance by public health agencies, including but not limited to the roles of Boards of Health and how they can most effectively help meet community needs for public health leadership, public health programming, and response to public health emergencies.

H-440.912, "Federal Block Grants and Public Health"

(1) Our AMA should collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated; such efforts may include the development of a common core of knowledge for public health and medical professionals, as well as educational vehicles to disseminate this information.

(2) Our AMA urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; and (c) involve national medical and public health organizations in deliberations on proposed changes in funding of public health programs.

(3) Our AMA will work with and through state and county medical societies to: (a) improve understanding of public health, including the distinction between publicly funded medical care and public health; (b) determine the roles and responsibilities of private physicians in public health, particularly in the delivery of personal medical care to underserved populations; (c) advocate for essential public health programs and services; (d) monitor legislative proposals that affect the nation's public health system; (e) monitor the growing influence of managed care organizations and other third party payers and assess the roles and responsibilities of these organizations for providing preventive services in communities; and (f) effectively communicate with practicing physicians and the general public about important public health issues.

(4) Our AMA urges state and county medical societies to: (a) establish more collegial relationships with public health agencies and increase interactions between private practice and public health physicians to develop mutual support of public health and clinical medicine; and (b) monitor and, to the extent possible, participate in state deliberations to ensure that block grant funds are used appropriately for health-related programs.

(5) Our AMA urges physicians and medical societies to establish community partnerships comprised of concerned citizens, community groups, managed care organizations, hospitals, and public health agencies to: (a) assess the health status of their communities and determine the scope and quality of population- and personal-based health services in their respective regions; and (b) develop performance objectives that reflect the public health needs of their states and communities.

6. Our AMA: (a) supports the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, in order to assure preservation of many critical public health programs for chronic disease prevention and health promotion in California and nationwide, and to maintain training of the public health physician workforce; and (b) will communicate support of the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, to the US Congress.

D-440.951, "One-Year Public Health Training Options for all Specialties"

1. Our AMA encourages additional funding for public health training for more physicians. 2. Our AMA, in conjunction with other appropriate organizations, supports the work of relevant groups to initiate the development of specific physician competencies for physicians engaged in public health practice. 3. Our AMA will inform medical students and physicians of existing opportunities for physician training in preparation for public health practice.

H-440.954, "Revitalization of Local Public Health Units for the Nation"

The AMA (1) reaffirms its support of state and local health departments; (2) recommends that health departments be directed by well qualified public health trained physicians; and (3) urges federal, state and local governments to study public health and preventive services, and urges the allocation of necessary resources to maintain these services at a high level of quality.

H-440.960, "The IOM Report (The Future of Public Health) and Public Health"

Our AMA

(1) encourages medical societies to establish liaison committees through which physicians in private practice and officials in public health can explore issues and mutual concerns involving public health activities and private practice;
(2) seeks increased dialogue, interchange, and cooperation among national organizations representing public health professionals and those representing physicians in private practice or academic medicine;
(3) actively supports promoting and contributing to increased attention to public health issues in its programs in medical science and education;
(4) continues to support the providing of medical care to poor and indigent persons through the private sector and the financing of this care through an improved Medicaid program;
(5) encourages public health agencies, as the IOM report suggests, to focus on assessment of problems, assurance of healthy living conditions, policy development, and activities such as those mentioned in the "Model Standards";
(6) encourages physicians and others interested in public health programs to apply the messages and injunctions of the IOM report as these fit their own situations and communities; and
(7) encourages physicians in private practice and those in public health to work cooperatively, striving to ensure better health for each person and an improved community as enjoined in the Principles of Medical Ethics.

H-440.969, "Meeting Public Health Care Needs Through Health Professions Education"

(1) Faculties of programs of health professions education should be responsive to the expectations of the public in regard to the practice of health professions. Faculties should consider the variety of practice circumstances in which new professionals will practice. Faculties should add curriculum segments to ensure that graduates are cognizant of the services that various health care professionals and alternative delivery systems provide. Because of the dominant role of public bodies in setting the standards for practice, courses on health policy are appropriate for health professions education. Additionally, governing boards of programs of education for the health professions, as well as the boards of the institutions in which these programs are frequently located, should ensure that programs respond to changing societal needs. Health professions educators should be involved in the education of the public regarding health matters. Programs of health professions education should continue to provide care to patients regardless of the patient's ability

to pay and they should continue to cooperate in programs designed to provide health practitioners in medically underserved areas.

(2) Faculty and administrators of health professions education programs should participate in efforts to establish public policy in regard to health professions education. Educators from the health professions should collaborate with health providers and practitioners in efforts to guide the development of public policy on health care and health professions education.

H-450.933, "Clinical Data Registries"

1. Our AMA encourages multi-stakeholder efforts to develop and fund clinical data registries for the purpose of facilitating quality improvements and research that result in better health care, improved population health, and lower costs.

D-478.974, "Quality Improvement in Clinical / Population Health Information Systems"

Our American Medical Association will invite other expert physician associations into the AMA consortium to further the quality improvement of electronic health records and population health as discussed in the consortium letter of January 21, 2015 to the National Coordinator of Health Information Technology.

REFERENCES

- ¹ Health Resources and Services Administration. Hospital Closings Likely to Increase. October 2017. Available at <https://www.hrsa.gov/enews/past-issues/2017/october-19/hospitals-closing-increase.html>. Accessed June 27, 2018.
- ² Centers for Medicare and Medicaid Services. CMS leverages Medicaid Program to Combat the Opioid Crisis. June 11, 2018. Available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-06-11.html>. Accessed June 27, 2018.
- ³ Girotti JA, Loy GL, Michel JL et al. The urban medicine program: developing physician-leaders to serve underserved urban communities. *Acad Med*. Available at https://journals.lww.com/academicmedicine/Fulltext/2015/12000/The_Urban_Medicine_Program_Developing.28.aspx. Accessed June 27, 2018.
- ⁴ Institute of Medicine. America's Health Care Safety Net: Intact but Endangered. Available at <https://www.nap.edu/catalog/9612/americas-health-care-safety-net-intact-but-endangered>. Accessed August 8, 2018.
- ⁵ Khullar D, Song Z, Chokshi DA. Safety-net health systems at risk: who bears the burden of uncompensated care? *Health Affairs Blog*. May 20, 2018. Available at <https://www.healthaffairs.org/doi/10.1377/hblog20180503.138516/full/>. Accessed August 8, 2018.
- ⁶ Children's Safety Network. Costs of Leading Childhood Injuries. November 2017. Available at <https://www.childrenssafetynetwork.org/sites/childrenssafetynetwork.org/files/Cost%20of%20Injuries%20Fact%20Sheet%20Nov%202017.pdf>. Accessed June 27, 2018.
- ⁷ Smith TM. Diabetes prevention saves big; find impact for your patient panel. *AMA Wire*. February 22, 2017. Available at <https://wire.ama-assn.org/delivering-care/diabetes-prevention-saves-big-find-impact-your-patient-panel>. Accessed June 27, 2018.
- ⁸ Swedler D, Miller T, Levy D. 70 Lives saved by laws and regulations that resulted from the Bloomberg road safety program. *Injury Prevention*. 2017;23:A26-A27.
- ⁹ Research America. Investment in research saves lives and money. Available at https://www.researchamerica.org/sites/default/files/Vaccine%20Fact%20Sheet_2016.pdf. Accessed June 27, 2018.
- ¹⁰ American Board of Preventive Medicine. Public Health and General Preventive Medicine. Available at <https://www.theabpm.org/become-certified/specialties/public-health-general-preventive-medicine/>. Accessed August 16, 2018.
- ¹¹ American College of Physicians. ACP Leadership Academy. Available at <https://www.acponline.org/meetings-courses/acp-courses-recordings/acp-leadership-academy>. Accessed August 7, 2018.
- ¹² American College of Physicians. ACP Leadership Academy Webinars. Available at <https://www.acponline.org/meetings-courses/acp-courses-recordings/acp-leadership-academy/webinars>. Accessed August 7, 2018.
- ¹³ Daniel H, Bornstein SS, Kane GC for the Health and Public Policy Committee of the American College of Physicians. Addressing social determinants to improve patient care and promote health equity: An American College of Physicians position paper. *Ann Int Med*. 2018;168:577-578.
- ¹⁴ American Medical Association. Creating a Community of Innovation: The Work of the AMA Accelerating Change in Medical Education Consortium. Available at https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/ace-monograph-interactive_0.pdf. Accessed August 16, 2018.
- ¹⁵ Koo K, Lapp I. Educating the next generation of physicians in public health: The MPH for medical students. *Public Health Rep*. 2014;129(5):460-464.
- ¹⁶ Little RG, Greer A, Clay M, McFadden C. Profile of public health leadership. *J Public Health Manag Pract*. 2016;22(5):479-481.
- ¹⁷ Association of American Medical Colleges. Directory of MD-MPH Educational Opportunities. Available at: <https://students-residents.aamc.org/applying-medical-school/article/directory-md-mph-educational-opportunities/>. Accessed June 20, 2018.
- ¹⁸ American Association of Colleges of Osteopathic Medicine. Dual Degree/Concurrent Programs. Available at: https://www.aacom.org/news-and-events/publications/2018-2019_cib/dual-degree-programs. Accessed June 20, 2018.
- ¹⁹ University of North Dakota School of Medicine and Health Sciences. Rural Opportunities in Medical Education. Available at <http://med.und.edu/rome/>. Accessed June 21, 2018.

- ²⁰ University of Wisconsin-Madison School of Medicine and Public Health. Wisconsin Academy for Rural Medicine. Available at <https://www.med.wisc.edu/education/md-program/warm/>. Accessed June 27, 2018.
- ²¹ University of Minnesota Medical Schools. Rural Physician Associate Program. Available at: <https://www.med.umn.edu/md-students/individualized-pathways/rural-physician-associate-program-rpap>. Accessed June 27, 2018.
- ²² Rural Health Partners Scholarship At Charleston Area Medical Center. Available at <https://medicine.hsc.wvu.edu/media/364010/2018-rural-health-partners-scholarship-program-brochure.pdf>. Accessed August 8, 2018.
- ²³ Accreditation Council for Graduate Medical Education. Common Program Requirements (Residency). Effective July 1, 2019. Available at <http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf>. Accessed June 29, 2018.
- ²⁴ American College of Preventive Medicine. Residency Programs. Available at <https://www.acpm.org/general/custom.asp?page=pmr>. Accessed June 21, 2018.
- ²⁵ American Board of Preventive Medicine. Combined Training Programs. Available at <https://www.theabpm.org/for-program-directors/combined-training-programs/>. Accessed June 21, 2018.
- ²⁶ Oral communication, Sylvia Etzel, Research Associate, American Medical Association.
- ²⁷ Written communication. Timothy Benton, Associate Professor, Program Director, and Regional Chair of Family Medicine, Texas Tech University Health Sciences Center School of Medicine.
- ²⁸ Association of American Medical Colleges. Public Health Pathways for Postresidents. Available at <https://students-residents.aamc.org/training-residency-fellowship/article/public-health-pathways-4/>. Accessed June 27, 2018.
- ²⁹ Centers for Disease Control. Epidemic Intelligence Service 2017 Annual Update. Available at <https://www.cdc.gov/eis/downloads/eis-annual-update-2017.pdf>. Accessed June 20, 2018.
- ³⁰ American Association of Public Health Physicians. Resources. Available at <https://www.aaphp.org/GeneralResources>. Accessed June 21, 2018.
- ³¹ American Public Health Association. APHA Internships & Fellowships. Available at: <https://www.apha.org/professional-development/apha-internships-and-fellowships>. Accessed, June 21, 2018.
- ³² National Association of County and City Health Officials. Resources. Available at <https://www.naccho.org/resources>. Accessed June 21, 2018.
- ³³ National Association of County and City Health Officials. NACCHO University. Available at <https://www.naccho.org/resources/naccho-university>. Accessed June 21, 2018.
- ³⁴ National Association of County and City Health Officials. NACCHO Consulting. Available at <https://www.naccho.org/naccho-consulting>. Accessed June 21, 2018.
- ³⁵ Centers for Disease Control and Prevention. Integrating Public Health in Health Professions Education: A Resource List for Students, Educators and Health Professionals. Available at <https://www.cdc.gov/learning/local/pdf/PH-education-resource-list.pdf>. Accessed June 27, 2018.
- ³⁶ RESOLVE. Public Health Leadership Forum. Available at <http://www.resolve.org/site-healthleadershipforum/>. Accessed June 27, 2018.
- ³⁷ Association of State and Territorial Health Officials. Educating the Workforce Towards Integration. Available at <http://www.astho.org/PCPHCollaborative/Workforce/Education-Resources/Primary-Care/>. Accessed June 27, 2018.
- ³⁸ Association of State and Territorial Health Officials. Center for Population Health Strategies. Available at http://www.astho.org/Programs/Clinical-to-Community-Connections/ASTHO-CPHS-Overview_FINAL/. Accessed June 27, 2018.
- ³⁹ National Network of Public Health Institutes. National Coordinating Center for Public Health Training. Available at https://nnphi.org/member/national-coordinating-center-for-public-health-training/?parent_id=60. Accessed June 29, 2018.
- ⁴⁰ Council of State and Territorial Epidemiologists. CSTE Fellowships. Available at <https://www.cste.org/page/CSTEFellowships>. Accessed August 16, 2018.
- ⁴¹ Hernandez LM, Munthali AW, eds. Training Physicians for Public Health Careers. 2007. The National Academies Press. Washington, D.C.
- ⁴² Association of Schools and Programs of Public Health. Fellowships and Internships. Available at <https://www.aspph.org/study/fellowships-and-internships/>. Accessed August 16, 2018.

- ⁴³ American Medical Association. STEPSforward. Adopting the ECHO model™ (Extension for Community Healthcare Outcomes). Available at <https://www.stepsforward.org/modules/project-echo>. Accessed June 27, 2018.
- ⁴⁴ Oral communication, Allison Winkler, Senior Practice Development Specialist, American Medical Association.
- ⁴⁵ Skochelak SE, Hawkins RE, Lawson LE et al. Health Systems Science. Elsevier. 2016.
- ⁴⁶ Smith T, Stankunas M, Czabanowska K et al. Principles of all-inclusive public health: developing a public health leadership curriculum. *Public Health*. 2015;129 (2):182-184.
- ⁴⁷ Reddy KS, Mathur MR, Negi S, et al. Redefining Public Health Leadership in the Sustainable Development Goal Era. *Health Policy and Planning*. 2017;32(5):757–759.
- ⁴⁸ Day M, Shickle D, Smith K et al. Training public health superheroes: five talents for public health leadership. *Journal of Public Health*. 2014;36(4):552-561.
- ⁴⁹ Shickle D, Day M, Smith K, et al. Mind the public health leadership gap: the opportunities and challenges of engaging high-profile individuals in the public health agenda. *Journal of Public Health*. 2014;36(4):562-567.
- ⁵⁰ Grimm BL, Watanabe-Galloway S, Britigan DG, et al. A qualitative analysis to determine the domains and skills necessary to lead in public health. *Journal of Leadership Studies*. 2017;11(1):6-19.
- ⁵¹ Grimm BL, Tibbits MK, Soliman GA et al. A retrospective evaluation to determine the effectiveness of public health leadership institutes. *Journal of Leadership Studies*. 2017;11(1):6-19.
- ⁵² Lantz PM. Gender and leadership in healthcare administrations: 21st century progress and challenges. *J Health Manag*. 2008;53(5):291-301.
- ⁵³ Carnes M, Johnson P, Klein W et al. Advancing women's health and women's leadership with endowed chairs in women's health. *Acad Med*. 2017;92(2):167-174.
- ⁵⁴ Harvard T.H. Chan School of Public Health. Emerging Women Executives in Health Care Program. Available at <https://www.hsph.harvard.edu/ecpe/programs/women-executives-in-health-care/>. Accessed August 8, 2018.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-I-18

Subject: Reconciliation of AMA Policy on Primary Care Workforce

Presented by: Carol Berkowitz, MD, Chair

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

INTRODUCTION

The goal of this report is to review, reconcile, and consolidate existing American Medical Association (AMA) policy on primary care workforce, eliminate duplication, and ensure that current policies are coherent and relevant. For each policy recommendation, a succinct but cogent justification is provided to support the proposed action. The most recent policy was deemed to supersede contradictory past AMA policies, and the language of each proposed policy was edited so that it is coherent and easily understood, without altering its meaning or intent.

POLICIES INCLUDED IN THIS REPORT

The following AMA policies are addressed in this report:

1. D-200.979, "Barriers to Primary Care as a Medical School Choice"
2. D-200.994, "Appropriations for Increasing Number of Primary Care Physicians"
3. H-200.956, "Appropriations for Increasing Number of Primary Care Physicians"
4. H-200.966, "Federal Financial Incentives and Medical Student Career Choice"
5. H-200.972, "Primary Care Physicians in the Inner City"
6. H-200.973, "Increasing the Availability of Primary Care Physicians"
7. H-200.975, "Availability, Distribution and Need for Family Physicians"
8. H-200.977, "Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians"
9. H-200.978, "Loan Repayment Programs for Primary Care Careers"
10. H-200.982, "Significant Problem of Access to Health Care in Rural and Urban Underserved Areas"
11. H-200.997, "Primary Care"
12. H-295.956, "Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers"
13. H-300.957, "Promoting Primary Care Services Through Continuing Medical Education"
14. H-310.973, "Primary Care Residencies in Community Hospitals"

SUMMARY AND RECOMMENDATIONS

This report encompasses a review of current AMA policies on primary care workforce to ensure such policy is consistent, accurate and up-to-date.

The new policy being proposed in recommendation 1, below, incorporates relevant portions of the 13 existing policies that are recommended for rescission in recommendation 2. Appendices A and B show a worksheet version and a clean text version, respectively, of the policy that is being proposed for adoption. Appendix C lists the 13 existing policies that are proposed for rescission.

Policy H-200.972, "Primary Care Physicians in the Inner City," contained elements that were not germane to the newly proposed policies. Accordingly, this policy is recommended for revision, as shown below, with the deleted portions to be reflected in the proposed policy. In addition, the policy's content and title have been expanded to reflect rural as well as urban populations of underserved patients.

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

1. That our American Medical Association (AMA) adopt as policy "Principles of and Actions to Address Primary Care Workforce" the language shown in column 1 in Appendix A to this report. (New HOD Policy)
2. That our AMA rescind the following policies, as shown in Appendix C:
 1. D-200.979, "Barriers to Primary Care as a Medical School Choice"
 2. D-200.994, "Appropriations for Increasing Number of Primary Care Physicians"
 3. H-200.956, "Appropriations for Increasing Number of Primary Care Physicians"
 4. H-200.966, "Federal Financial Incentives and Medical Student Career Choice"
 5. H-200.973, "Increasing the Availability of Primary Care Physicians"
 6. H-200.975, "Availability, Distribution and Need for Family Physicians"
 7. H-200.977, "Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians"
 8. H-200.978, "Loan Repayment Programs for Primary Care Careers"
 9. H-200.982, "Significant Problem of Access to Health Care in Rural and Urban Underserved Areas"
 10. H-200.997, "Primary Care"
 11. H-295.956, "Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers"
 12. H-300.957, "Promoting Primary Care Services Through Continuing Medical Education"
 13. H-310.973, "Primary Care Residencies in Community Hospitals" (Rescind HOD Policy)
3. That H-200.972, "Primary Care Physicians in the Inner City," be amended by addition and deletion, and a title change, to read as follows:

"Primary Care Physicians in Underserved Areas"

Our AMA should pursue the following plan to improve the recruitment and retention of physicians in ~~the inner-city~~ underserved areas:

- (1) Encourage the creation and pilot-testing of school-based, ~~church~~ faith-based, and community-based urban/rural "family Hhealth clinics, with an emphasis on health education, prevention, primary care, and prenatal care.

- (2) Encourage the affiliation of these family health clinics with ~~urban~~local medical schools and teaching hospitals.
- ~~(3) Promote medical student rotations through the various inner-city neighborhood family health clinics, with financial assistance to the clinics to compensate their teaching efforts.~~
- ~~(4) Encourage medical schools and teaching hospitals to integrate third- and fourth-year undergraduate medical education and residency training into these teams.~~
- (53) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.
- ~~(6) Study the concept of having medical schools with active outreach programs in the inner city offer additional training to physicians from nonprimary care specialties who are interested in achieving specific primary care competencies.~~
- ~~(7) Consider expanding opportunities for practicing physicians in other specialties to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family practice, internal medicine, pediatrics, etc. These may be developed so that they are part-time, thereby allowing physicians enrolling in these programs to practice concurrently.~~
- (84) Encourage the AMA Senior Physicians ~~Services Group~~ Section to consider the ~~use~~ involvement of retired physicians in underserved ~~urban~~ settings ~~of retired physicians~~, with appropriate mechanisms to ensure their competence.
- (95) Urge ~~urban~~ hospitals and medical societies to develop opportunities for physicians to work part-time to staff ~~urban~~ health clinics that help meet the needs of underserved patient populations.
- ~~(106)~~ Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who ~~serve the inner-city poor~~help meet the needs of underserved patient populations.
- ~~(11) Urge medical schools to seek out those students whose profiles indicate a likelihood of practicing in underserved urban areas, while establishing strict guidelines to preclude discrimination.~~
- ~~(12) Encourage medical school outreach activities into secondary schools, colleges, and universities to stimulate students with these profiles to apply to medical school.~~
- ~~(13) Encourage medical schools to continue to change their curriculum to put more emphasis on primary care.~~
- ~~(14) Urge state medical associations to support the development of methods to improve physician compensation for serving this population, such as Medicaid case management programs in their respective states.~~

- 1 (15) Urge ~~urban~~ hospitals and medical centers to seek out the use of available military
2 health care resources and personnel, which can be used to ~~fill gaps in urban~~
3 ~~care~~ help meet the needs of underserved patient populations.
4
5 (16) ~~Urge CMS to explore the use of video and computer capabilities to improve access~~
6 ~~to and support for urban primary care practices in underserved settings.~~
7
8 (17) ~~Urge urban hospitals, medical centers, state medical associations, and specialty~~
9 ~~societies to consider the expanded use of mobile health care capabilities.~~
10
11 (18) ~~Continue to urge measures to enhance payment for primary care in the inner city.~~
12 (Modify Current HOD Policy)

Fiscal note: \$1,000.

APPENDIX A: PROPOSED AMA POLICY: “PRINCIPLES OF AND ACTIONS TO ADDRESS PRIMARY CARE WORKFORCE” (WORKSHEET VERSION)

Note: The left column shows the proposed language for adoption ; the right column shows the original language that is being modified and its policy number, if any.

Proposed language for adoption	Original language
1. Our patients require a sufficient, well-trained supply of primary care physicians—family physicians, general internists, general pediatricians, and obstetricians/gynecologists—to meet the nation’s current and projected demand for health care services.	The AMA believes that there should be a sufficient supply of primary care physicians - family physicians, general internists, general pediatricians, and obstetricians/gynecologists. In order to achieve this objective: H-200.997
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).	(new)
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components:	4. Our AMA will collaborate with appropriate organizations to support the development of innovative models to recruit medical students interested in primary care, to train primary care physicians, and to enhance the image of primary care practice. D-200.979
a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans;	(3) It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians and improved recruitment of medical school graduates into primary care specialties. H-200.997
b) Curriculum changes throughout the medical education continuum;	It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians, improved recruitment of medical school graduates and training a sufficient number of
c) Expanded financial aid and debt relief options;	
d) Financial and logistical support for primary care practice, including	

Proposed language for adoption	Original language
<p>adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and</p> <p>e) Support for research and advocacy related to primary care.</p>	<p>primary care physicians to meet projected national needs. H-200.977</p> <p>The AMA will continue to recommend specific strategies to increase the availability of primary care physicians, which may include curricular modification, financing mechanisms for medical education and research, financial aid options, and modifications of the practice environment. H-200.975</p> <p>2. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including: a. admissions policies ...D-200.979</p>
<p>4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.</p>	<p>(2) The admission process should be sensitive to the institution's mission. Those schools with missions that include primary care should consider those predictor variables known to be associated with choice of these specialties. H-200.973</p>
<p>5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.</p>	<p>(3) Through early recruitment and outreach activities, attempts should be made to increase the pool of applicants likely to practice primary care. H-200.973</p> <p>(11) Urge medical schools to seek out those students whose profiles indicate a likelihood of practicing in underserved urban areas, while establishing strict guidelines to preclude discrimination. H-200.972</p> <p>(12) Encourage medical school outreach activities into secondary schools, colleges, and universities to stimulate students with these profiles to apply to medical school. H-200.972</p>
<p>6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.</p>	<p>(7) Medical schools should provide career counseling related to the choice of a primary care specialty. H-200.973</p> <p>5. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including: ... b. utilization of primary care physicians in the roles of</p>

Proposed language for adoption	Original language
	teachers, mentors, and role models.... D-200.979
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.	Federal financial assistance programs aimed at stimulating interest in primary care should have the following characteristics: (1) Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities. H-200.966
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued, including such innovations as a three-year medical school curriculum that leads directly to primary care residency programs. The establishment of appropriate administrative units for family medicine should be encouraged.	(1) Voluntary efforts to develop and expand both undergraduate and graduate programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for family practice should be encouraged. H-200.997
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.	(4) Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. H-200.973
	(13) Encourage medical schools to continue to change their curriculum to put more emphasis on primary care. H-200.972
	(1) Each medical school should reexamine its institutional goals and objectives, including the extent of its commitment to primary care. Those schools recognizing a commitment related to primary care should make this an explicit part of the mission, and set institutional priorities accordingly. H-200.973
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.	(5) All four years of the curriculum in every medical school should provide experiences in primary care for all students. These experiences should feature increasing levels of student responsibility and use of ambulatory and community settings. H-200.973
	5. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including: ... c. educational

Proposed language for adoption	Original language
	experiences in community-based primary care settings. D-200.979
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.	(2) Federal support, without coercive terms, should be available to institutions needing financial support for the expansion of resources for both undergraduate and graduate programs designed to increase the number of primary care physicians. H-200.997
	7. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide graduate medical education for resident physicians and fellows in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. D-200.979
	8. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide undergraduate medical education for students in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. D-200.979
	Our AMA encourages the Bureau of Health Professions to establish a series of grants for innovative pilot programs that change the current approaches to medical education at the undergraduate/graduate level in the primary care area which can be evaluated for their effectiveness in increasing the number of students choosing primary care careers. H-295.956
	2. Our AMA will encourage the Centers for Medicare & Medicaid Services, American Osteopathic Association, Accreditation Council for Graduate Medical Education, American Board of Medical Specialties and the Association of American Medical Colleges to foster the development of innovative training programs for medical students, residents and fellows in rural and

Proposed language for adoption	Original language
	underserved areas so that the number of physicians increases in these underserved areas, which would facilitate the elimination of geographic, racial, and other health care disparities. H-200.982
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.	(3) Promote medical student rotations through the various inner-city neighborhood family health clinics, with financial assistance to the clinics to compensate their teaching efforts. H-200.972
	(4) Encourage medical schools and teaching hospitals to integrate third- and fourth-year undergraduate medical education and residency training into these teams. H-200.972
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).	(8) The curriculum in primary care residency programs and the sites used for training should be consistent with the objective of training generalist physicians. H-200.973
	Our AMA advocates that the Accreditation Council for Graduate Medical Education support primary care residency programs, including community hospital based programs. H-310.973
	6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) to develop an accreditation environment and novel pathways that promote innovations in training that use progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model. D-200.979
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.	(6) The visibility of primary care faculty members should be enhanced within the medical school and positive attitudes toward primary care among all faculty members should be encouraged. H-200.973
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure	(10) Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, and enhanced efforts to eliminate “hassle” and unnecessary paper work should be undertaken. H-200.973

Proposed language for adoption	Original language
professional satisfaction and practice sustainability.	
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.	(9) There should be increased financial incentives for physicians practicing primary care. H-200.973
	1. Our AMA encourages state legislatures and the Congress of the United States to recognize this significant problem and to develop rapidly incentives to make practice in rural and urban underserved areas more attractive to primary care physicians in order to provide access to necessary medical services in these areas. H-200.982
	(18) Continue to urge measures to enhance payment for primary care in the inner city. H-200.972
	(14) Urge state medical associations to support the development of methods to improve physician compensation for serving this population, such as Medicaid case management programs in their respective states. H-200.972
	2. Our AMA supports existing programs and advocate for the introduction of new programs in the public and private sectors that decrease the debt load of physicians who choose to practice in a primary care specialty. D-200.979
	The AMA will (1) work with federal and state governments to develop incentive programs, such as loan repayment, to encourage practice in underserved areas, H-200.978
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and	1. In collaboration with relevant specialty societies, our AMA will take the following actions related to reimbursement for primary care physician services: a. Continue to advocate for the recommendations from the AMA/Specialty Society RVS Update

Proposed language for adoption	Original language
coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.	Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions. b. Work to assure that private payers fully recognize the value of E&M services, incorporating the RUC recommended increases adopted for the most current Medicare RBRVS. D-200.979
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.	9. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919. D-200.979
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.	(11) There should be educational support systems for primary care physicians, especially those practicing in underserved areas. H-200.973
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.	(17) Urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities. H-200.972
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.	(16) Urge CMS to explore the use of video and computer capabilities to improve access to and support for urban primary care practices in underserved settings. H-200.972
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.	The AMA urges accredited continuing medical education sponsors to promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services. H-300.957
23. Practicing physicians in other specialties—particularly those practicing in underserved urban or rural areas—should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition,	(7) Consider expanding opportunities for practicing physicians in other specialties to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family practice, internal medicine, pediatrics, etc. These may be developed so that they are part-time, thereby allowing physicians enrolling in these programs to practice concurrently. H-200.972

Proposed language for adoption	Original language
part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.	(6) Study the concept of having medical schools with active outreach programs in the inner city offer additional training to physicians from nonprimary care specialties who are interested in achieving specific primary care competencies. H-200.972
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.	Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747. H-200.956
	Our AMA will encourage members to communicate with their US Senators and Representatives to support Public Health Service Act, Title VII, Section 747. D-200.994
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.	Federal financial assistance programs aimed at stimulating interest in primary care should have the following characteristics:... (2) There should be an analysis of outcome data for federal financial assistance programs, to determine if they are having the desired effects and a study of the impact of these programs on disadvantaged and underrepresented groups of students. H-200.966
	(2) engage in research to identify all factors which deter students and physicians from choosing and remaining in primary care disciplines H-200.978
	3. Our AMA will continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. D-200.979
	and (3) use this information to support and implement AMA policy to enhance primary care as a career choice. H-200.978

APPENDIX B: PROPOSED AMA POLICY: “PRINCIPLES OF AND ACTIONS TO ADDRESS PRIMARY CARE WORKFORCE” (TEXT VERSION)

1. Our patients require a sufficient, well-trained supply of primary care physicians—family physicians, general internists, general pediatricians, and obstetricians/gynecologists—to meet the nation’s current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components:
 - a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans;
 - b) Curriculum changes throughout the medical education continuum;
 - c) Expanded financial aid and debt relief options;
 - d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and
 - e) Support for research and advocacy related to primary care.
4. **Admissions and recruitment:** The medical school admissions process should reflect the specific institution’s mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. **Career counseling and exposure to primary care:** Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. **Curriculum:** Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued, including such innovations as a three-year medical school curriculum that leads

directly to primary care residency programs. The establishment of appropriate administrative units for family medicine should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. **Support for practicing primary care physicians:** Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and

decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties—particularly those practicing in underserved urban or rural areas—should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. **Research:** Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

APPENDIX C: AMA POLICIES AND DIRECTIVES PROPOSED FOR RESCISSION

1. *D-200.979, "Barriers to Primary Care as a Medical School Choice"*

1. In collaboration with relevant specialty societies, our AMA will take the following actions related to reimbursement for primary care physician services: a. Continue to advocate for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions. b. Work to assure that private payers fully recognize the value of E&M services, incorporating the RUC recommended increases adopted for the most current Medicare RBRVS.
2. Our AMA supports existing programs and advocate for the introduction of new programs in the public and private sectors that decrease the debt load of physicians who choose to practice in a primary care specialty.
3. Our AMA will continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions.
4. Our AMA will collaborate with appropriate organizations to support the development of innovative models to recruit medical students interested in primary care, to train primary care physicians, and to enhance the image of primary care practice.
5. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including: a. admissions policies b. utilization of primary care physicians in the roles of teachers, mentors, and role models, and c. educational experiences in community-based primary care settings.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) to develop an accreditation environment and novel pathways that promote innovations in training that use progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model.
7. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide graduate medical education for resident physicians and fellows in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice.
8. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide undergraduate medical education for students in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice.
9. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

CME Rep. 3, I-08; Appended: CME Rep. 8, A-10; Modified: CCB/CLRPD Rep. 2, A-14

2. *D-200.994, "Appropriations for Increasing Number of Primary Care Physicians"*

Our AMA will encourage members to communicate with their US Senators and Representatives to support Public Health Service Act, Title VII, Section 747.

Res. 814, I-03; Reaffirmed: BOT Rep. 28, A-13

3. *H-200.956, "Appropriations for Increasing Number of Primary Care Physicians"*

Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747. Res. 814, I-03; Reaffirmation I-08

4. *H-200.966, "Federal Financial Incentives and Medical Student Career Choice"*

To further expand policy the AMA has adopted the following:

Federal financial assistance programs aimed at stimulating interest in primary care should have the following characteristics:

(1) Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

(2) There should be an analysis of outcome data for federal financial assistance programs, to determine if they are having the desired effects and a study of the impact of these programs on disadvantaged and underrepresented groups of students.

CME Rep. 6, A-94; Reaffirmed: CME Rep. 2, A-05; Modified: CME Rep. 13, A-06; Reaffirmation I-08

5. *H-200.973, "Increasing the Availability of Primary Care Physicians"*

It is the policy of the AMA that:

(1) Each medical school should reexamine its institutional goals and objectives, including the extent of its commitment to primary care. Those schools recognizing a commitment related to primary care should make this an explicit part of the mission, and set institutional priorities accordingly.

(2) The admission process should be sensitive to the institution's mission. Those schools with missions that include primary care should consider those predictor variables known to be associated with choice of these specialties.

(3) Through early recruitment and outreach activities, attempts should be made to increase the pool of applicants likely to practice primary care.

(4) Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective.

(5) All four years of the curriculum in every medical school should provide experiences in primary care for all students. These experiences should feature increasing levels of student responsibility and use of ambulatory and community settings.

(6) The visibility of primary care faculty members should be enhanced within the medical school and positive attitudes toward primary care among all faculty members should be encouraged.

(7) Medical schools should provide career counseling related to the choice of a primary care specialty.

(8) The curriculum in primary care residency programs and the sites used for training should be consistent with the objective of training generalist physicians.

(9) There should be increased financial incentives for physicians practicing primary care.

(10) Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, and enhanced efforts to eliminate "hassle" and unnecessary paper work should be undertaken.

(11) There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

(12) States should be encouraged to provide positive incentives--such as scholarship or loan repayment programs, relief of professional liability burdens and reduction of duplicative administrative responsibilities--to support medical students' choice of a primary care specialty. The

imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

CME Rep. N, A-93; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 13, A-06; Reaffirmed: CME Rep. 1, I-08; Reaffirmation I-08

6. *H-200.975, "Availability, Distribution and Need for Family Physicians"*

The AMA will continue to recommend specific strategies to increase the availability of primary care physicians, which may include curricular modification, financing mechanisms for medical education and research, financial aid options, and modifications of the practice environment. Sub. Res. 306, I-92; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, I-03; Reaffirmation I-08

7. *H-200.977, "Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians"*

It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians, improved recruitment of medical school graduates and training a sufficient number of primary care physicians to meet projected national needs.

Res. 306, I-91; Reaffirmed: BOT Rep. GG, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmation I-08

8. *H-200.978, "Loan Repayment Programs for Primary Care Careers"*

The AMA will (1) work with federal and state governments to develop incentive programs, such as loan repayment, to encourage practice in underserved areas, (2) engage in research to identify all factors which deter students and physicians from choosing and remaining in primary care disciplines and (3) use this information to support and implement AMA policy to enhance primary care as a career choice.

BOT Rep. EEE, A-91; Reaffirmed: BOT Rep. GG, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmation I-06; Reaffirmed: CME Rep. 1, I-08

9. *H-200.982, "Significant Problem of Access to Health Care in Rural and Urban Underserved Areas"*

1. Our AMA encourages state legislatures and the Congress of the United States to recognize this significant problem and to develop rapidly incentives to make practice in rural and urban underserved areas more attractive to primary care physicians in order to provide access to necessary medical services in these areas.

2. Our AMA will encourage the Centers for Medicare & Medicaid Services, American Osteopathic Association, Accreditation Council for Graduate Medical Education, American Board of Medical Specialties and the Association of American Medical Colleges to foster the development of innovative training programs for medical students, residents and fellows in rural and underserved areas so that the number of physicians increases in these underserved areas, which would facilitate the elimination of geographic, racial, and other health care disparities.

Sub. Res. 35, I-90; Reaffirmed: BOT Rep. GG, I-92; Reaffirmation A-01; Modified: CME Rep. 2, I-03; Appended: Res. 320, A-10

10. H-200.997, "Primary Care"

The AMA believes that there should be a sufficient supply of primary care physicians - family physicians, general internists, general pediatricians, and obstetricians/gynecologists. In order to achieve this objective:

(1) Voluntary efforts to develop and expand both undergraduate and graduate programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for family practice should be encouraged.

(2) Federal support, without coercive terms, should be available to institutions needing financial support for the expansion of resources for both undergraduate and graduate programs designed to increase the number of primary care physicians.

(3) It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians and improved recruitment of medical school graduates into primary care specialties.

CME Rep. C, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: BOT Rep. GG, I-92;
Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, I-03; Reaffirmation I-08

11. H-295.956, "Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers"

Our AMA encourages the Bureau of Health Professions to establish a series of grants for innovative pilot programs that change the current approaches to medical education at the undergraduate/graduate level in the primary care area which can be evaluated for their effectiveness in increasing the number of students choosing primary care careers.

Res. 173, I-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10

12. H-300.957, "Promoting Primary Care Services Through Continuing Medical Education"

The AMA urges accredited continuing medical education sponsors to promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

Res. 311, A-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14

13. H-310.973, "Primary Care Residencies in Community Hospitals"

Our AMA advocates that the Accreditation Council for Graduate Medical Education support primary care residency programs, including community hospital based programs.

Sub. Res. 27, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-08

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-I-18

Subject: Reconciliation of AMA Policy on Medical Student Debt

Presented by: Carol Berkowitz, MD, Chair

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

INTRODUCTION AND METHODS

The goal of this report is to review, reconcile, and consolidate existing American Medical Association (AMA) policy on medical student debt, eliminate duplication, and ensure that current policies are coherent and relevant. For each policy recommendation, a succinct but cogent justification is provided to support the proposed action. If a contradiction in policies was discovered, the most recent policy was deemed to supersede past AMA policies, and the language of each proposed policy was then edited so that it would be coherent and easily understood, without altering its meaning or intent.

POLICIES INCLUDED IN THIS REPORT

The following AMA policies are addressed in this report:

1. D-305.956, "AMA Participation in Reducing Medical Student Debt"
2. D-305.957, "Update on Financial Aid Programs"
3. D-305.962, "Tax Deductibility of Student Loan Payments"
4. D-305.966, "Reinstatement of Economic Hardship Loan Deferment"
5. D-305.970, "Proposed Revisions to AMA Policy on Medical Student Debt"
6. D-305.975, "Long-Term Solutions to Medical Student Debt"
7. D-305.977, "Deductibility of Medical Student Loan Interest"
8. D-305.978, "Mechanisms to Reduce Medical Student Debt"
9. D-305.979, "State and Local Advocacy on Medical Student Debt"
10. D-305.980, "Immediate Legislative Solutions to Medical Student Debt"
11. D-305.981, "Financing Federal Consolidation Loans"
12. D-305.993, "Medical School Financing, Tuition, and Student Debt"
13. D-405.986, "Student Loans and Medicare / Medicaid Participation"
14. H-305.926, "Supporting Legislation to Create Student Loan Savings Accounts"
15. H-305.928, "Proposed Revisions to AMA Policy on Medical Student Debt"
16. H-305.932, "State and Local Advocacy on Medical Student Debt"
17. H-305.948, "Direct Loan Consolidation Program"
18. H-305.954, "Repayment of Medical School Loans"
19. H-305.965, "Student Loans"
20. H-305.980, "Student Loan Repayment Grace Period"
21. H-305.991, "Repayment of Educational Loans"

SUMMARY AND RECOMMENDATIONS

This report encompasses a review of current AMA policies on medical student debt to ensure such policy is consistent, accurate and up-to-date. The new policy being proposed in recommendation 1, below (shown in Appendix A), incorporates relevant portions of the 21 existing policies that are recommended for rescission in recommendation 2. Appendix B shows a clean text version of the policy that is being proposed for adoption. Appendix C lists all 21 policies that are proposed for rescission. The (relatively few) segments of policy that are not being retained in the proposed new policy are listed in Appendix D.

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

1. That our American Medical Association (AMA) adopt as policy “Principles of and Actions to Address Medical Education Costs and Student Debt” the language shown in column 1 of Appendix A of this report. (New HOD Policy)
2. That our AMA rescind the following policies, as shown in Appendix C:
 1. D-305.956, “AMA Participation in Reducing Medical Student Debt”
 2. D-305.957, “Update on Financial Aid Programs”
 3. D-305.962, “Tax Deductibility of Student Loan Payments”
 4. D-305.966, “Reinstatement of Economic Hardship Loan Deferment”
 5. D-305.970, “Proposed Revisions to AMA Policy on Medical Student Debt”
 6. D-305.975, “Long-Term Solutions to Medical Student Debt”
 7. D-305.977, “Deductibility of Medical Student Loan Interest”
 8. D-305.978, “Mechanisms to Reduce Medical Student Debt”
 9. D-305.979, “State and Local Advocacy on Medical Student Debt”
 10. D-305.980, “Immediate Legislative Solutions to Medical Student Debt”
 11. D-305.981, “Financing Federal Consolidation Loans”
 12. D-305.993, “Medical School Financing, Tuition, and Student Debt”
 13. D-405.986, “Student Loans and Medicare / Medicaid Participation”
 14. H-305.926, “Supporting Legislation to Create Student Loan Savings Accounts”
 15. H-305.928, “Proposed Revisions to AMA Policy on Medical Student Debt”
 16. H-305.932, “State and Local Advocacy on Medical Student Debt”
 17. H-305.948, “Direct Loan Consolidation Program”
 18. H-305.954, “Repayment of Medical School Loans”
 19. H-305.965, “Student Loans”
 20. H-305.980, “Student Loan Repayment Grace Period”
 21. H-305.991, “Repayment of Educational Loans” (Rescind HOD Policy)

Fiscal note: \$1,000.

APPENDIX A: PROPOSED AMA POLICY: “PRINCIPLES OF AND ACTIONS TO ADDRESS MEDICAL EDUCATION COSTS AND STUDENT DEBT” (WORKSHEET VERSION)

Note: The left column shows the proposed language for adoption ; the right column shows the original language that is being modified and its policy number, if any.

Proposed language for adoption	Original language
The costs of medical education should never be a barrier to pursuit of a career in medicine nor to the decision to practice in a given specialty.	3. Financial aid opportunities, including scholarship and loan repayment programs, should be available so that individuals are not denied an opportunity to pursue medical education because of financial constraints. H-305.928
	4. A sufficient breadth of financial aid opportunities should be available so that student specialty choice is not constrained based on the need for financial assistance. H-305.928
To help address this issue, our American Medical Association (AMA) will: 1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.	Our AMA will: 1. Collaborate, based on AMA policy, with members of the Federation and the medical education community, and with other interested organizations, to achieve the following immediate public- and private-sector advocacy goals: D-305.970
	1. Our AMA will make reducing medical student debt a high priority for legislative and other action and will collaborate with other organizations to study how costs to students of medical education can be reduced. H-305.928
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs—such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector—to promote practice in underserved areas, the military, and academic medicine or clinical research.	(a) Support expansion of and adequate funding for federal scholarship and loan repayment programs, such as those from the National Health Service Corps, the Indian Health Service, the Armed Forces, and the Department of Veterans Affairs, and for comparable programs at the state level. D-305.970
	2. Our AMA will vigorously advocate for ongoing, adequate funding for federal and state programs that provide scholarship or loan repayment funds in return for service, including funding in return for practice in underserved areas, participation in the military, and participation in academic medicine or clinical research. Obtaining adequate support for the National Health Service Corps and similar programs, tied to the demand for participation in the programs, should be a focus for AMA advocacy efforts. D-305.993
	5. Our AMA supports the creation of new and the expansion of existing medical education

Proposed language for adoption	Original language
	financial assistance programs from the federal government, the states, and the private sector. H-305.928
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.	(b) Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research. D-305.970
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.	(2) advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas; D-305.975
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.	(5) encourage the National Health Services Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas. D-305.975
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.	Our AMA will actively work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of post-graduate trainees with educational debt. D-305.966
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.	Our AMA will advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans. H-305.926
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.	8. Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of ...eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans. D-305.993
	(d) Ensure that the Higher Education Act and other legislation allow interest from medical

Proposed language for adoption	Original language
	student loans to be fully tax deductible. D-305.970
	Our AMA will draft legislation allowing 100% tax deductibility of student loan interest. D-305.962
	Our AMA will work toward 100% tax deductibility of medical student loan interest on federal and state income tax returns. D-305.977
	7. Our AMA supports legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit the full deductibility of interest on student loans. H-305.928
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).	(f) Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs). D-305.970
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.	(g) Support stable funding for medical education programs to limit excessive tuition increases. D-305.970
	(4) collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided; and D-305.975
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.	(3) work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment; D-305.975
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education;	2. Encourage medical schools to study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, combined baccalaureate/MD programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education. D-305.970
(b) Engage in fundraising activities to increase the availability of	(e) Encourage medical schools, with the support of the Federation, to engage in fundraising

Proposed language for adoption	Original language
scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs;	activities devoted to increasing the availability of scholarship support. D-305.970
	(3) encourage members of the Federation to develop or enhance financial aid opportunities for medical students; D-305.978
	(5) continue to collect and disseminate information to assist members of the Federation (state medical societies and specialty societies) and medical schools to establish or expand financial aid programs; and D-305.978
	Our AMA will: (1) encourage medical schools and state medical societies to consider the creation of self-managed, low-interest loan programs for medical students, and collect and disseminate information on such programs; D-305.975
	(2) urge state medical societies to actively solicit funds (either directly or through their Foundations) for the establishment and expansion of medical student scholarships, and that our AMA develop a set of guidelines and suggestions to assist states in carrying out such initiatives. D-305.979
(c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students;	(3) encourages medical schools to cooperate with undergraduate institutions to establish collaborative debt counseling for entering first-year medical students. H-305.932
(d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students;	8. Medical students should not be forced to jeopardize their education by the need to seek employment. Any decision on the part of the medical student to seek employment should take into account his/her academic situation. Medical schools should have policies and procedures in place that allow for flexible scheduling in the case that medical students encounter financial difficulties that can be remedied only by employment. Medical schools should consider creating opportunities for paid employment for medical students. H-305.928
(e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation;	(3) encourages medical school financial aid officers to counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation. H-305.991

Proposed language for adoption	Original language
(f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen;	5. Our AMA supports a requirement that medical schools inform students of all government loan opportunities and requires disclosure of reasons that preferred lenders were chosen. D-305.993
(g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees;	Our AMA: (1) opposes the charging of broad and ill-defined student fees by medical schools, such as but not limited to professional fees, encouraging in their place fees that are earmarked for specific and well-defined purposes; H-305.932
(h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies;	(2) encourages medical schools to use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; and H-305.932
(i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.	2. Our AMA supports stable funding for medical schools to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue and should oppose mid-year and retroactive tuition increases. H-305.928
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.	Our AMA will: (1) support and encourage our state medical societies to support further expansion of state loan repayment programs, and in particular expansion of those programs to cover physicians in non-primary care specialties; and D-305.979
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals:	Our AMA will: (1) take an active advocacy role during the upcoming reauthorization of the Higher Education Act and other pending legislation, to achieve the following goals: D-305.978
	Our AMA will: (1) endorse and actively lobby for the Reauthorization of the Higher Education Act, including: D-305.980
(a) Eliminating the single holder rule;	(1) (a) eliminating the single holder rule, D-305.978
	(1) (a) Elimination of the “single-holder” rule; D-305.980
(b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training;	(c) With each reauthorization of the Higher Education Act and at every other legislative opportunity, proactively pursue loan consolidation terms that favor students and ensure that loan deferment is available for the entire duration of residency and fellowship training. D-305.970

Proposed language for adoption	Original language
	(1) (b) making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; D-305.978
	(1) (d) Broadening of the definition of economic hardship as used to determine eligibility for student loan deferment; D-305.980
	(1) (c) Expansion of the deferment period for loan repayment to cover the entire duration of residency and fellowship; D-305.980
	Our AMA: (1) reaffirms its support of legislation that would defer the repayment of loans for education until the completion of residency training; and H-305.965
	(2) will lobby for deferment of medical student loans for the full initial residency period. H-305.965
	8. Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of increasing loan deferment through the period of residency.... D-305.993
(c) Retaining the option of loan forbearance for residents ineligible for loan deferment;	(1) (c) retaining the option of loan forbearance for residents ineligible for loan deferment, D-305.978
	(1) (e) Retention of the option of loan forbearance for residents who are ineligible for student loan deferment; D-305.980
(d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”;	(1) (d) including, explicitly, dependent care expenses in the definition of the “cost of attendance,” D-305.978
	(1) (f) Inclusion of dependent care expenses in the definition of “cost of attendance”; and D-305.980
(e) Including room and board expenses in the definition of tax-exempt scholarship income;	(1) (e) including room and board expenses in the definition of tax-exempt scholarship income, D-305.978
	(2) (c) Include room and board expenses in the definition of tax-exempt scholarship income; D-305.980
(f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed	(1) (f) continuing the loan consolidation program, including the ability to “lock in” a fixed interest rate, and D-305.978

Proposed language for adoption	Original language
interest rate, and giving consideration to grace periods in renewals of federal loan programs;	<p>The AMA supports the Individual Education Account/Direct Loan Consolidation Program. H-305.948</p> <p>(1) (b) Continuation of the consolidation loan program and a consolidator's ability to lock in a fixed interest rate; D-305.980</p> <p>The AMA supports giving consideration to grace periods in renewals of federal loan programs and attempting to secure the most favorable repayment terms. H-305.980</p>
(g) Adding the ability to refinance Federal Consolidation Loans;	<p>(1) (g) adding the ability to refinance Federal Consolidation Loans; D-305.978</p> <p>Our AMA will: (1) support the refinancing of Federal Consolidation Loans; and D-305.981</p> <p>Our AMA will: (2) actively advocate for modification of pending and future legislation which that provides the opportunity to refinance Federal Consolidation Loans. D-305.981</p>
(h) Eliminating the cap on the student loan interest deduction;	(2) (a) Eliminate the cap on the student loan interest deduction; D-305.980
(i) Increasing the income limits for taking the interest deduction;	(2) (b) Increase the income limits for taking the interest deduction; D-305.980
(j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001;	(2) (d) Make permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001. D-305.980
(k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating;	<p>11. Our AMA opposes any stipulations in loan repayment programs that place greater burdens upon married couples than for similarly-situated couples who are cohabitating. H-305.928</p>
(l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.	(2) urges increased efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students; and H-305.991
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.	(2) continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases; D-305.978
16. Continue to study medical education financing, so as to identify long-term	(6) continue to study medical education financing, so as to identify long-term strategies

Proposed language for adoption	Original language
strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.	to mitigate the debt burden of medical students. D-305.978 (b) continue to monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location. D-305.957
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.	3. Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition. D-305.993
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.	4. Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students. D-305.993
	6. Our AMA will urge the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements to include a requirement that financial planning/debt management counseling be provided for resident physicians. D-305.993
	7. Our AMA will work with other organizations, including the Association of American Medical Colleges, residency program directors groups, and members of the Federation, to develop and disseminate standardized information, for example, computer-based modules, on financial planning/debt management for use by medical students, resident physicians, and young physicians. D-305.993
	6. Medical schools should have programs in place to assist students to limit their debt. This includes making scholarship support available, counseling students about financial aid availability, and providing comprehensive debt management/financial planning counseling. H-305.928
	(4) continue to monitor the availability of financial aid opportunities and financial planning/debt management counseling at medical schools, and share innovative approaches with the medical education community; D-305.978
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA	Our AMA will seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. D-405.986

Proposed language for adoption	Original language
believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.	<p>The AMA (1) believes that it is improper for any physician not to repay his or her educational loans; H-305.991</p> <p>9. Financial obligations, such as repayment of loans, and service obligations made in exchange for financial assistance, should be fulfilled. There should be mechanisms to assist physicians who are experiencing hardship in meeting these obligations. H-305.928</p>
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will:	10. Our AMA supports the expansion and increase of medical student and physician benefits under Public Service Loan Forgiveness. H-305.928
(a) Advocate that all resident/fellow physicians have access to PSLF during their training years;	Our AMA will: (a) through the advocacy process, explore the possibility of assuring that all resident physicians and fellows have access to the Public Service Loan Forgiveness Program for the time they are in residency and fellowship training; and D-305.957
(b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs;	9. Our AMA will advocate against putting a monetary cap on federal loan forgiveness programs. D-305.993
(c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed;	10. Our AMA will: (a) advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; (b) work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be at least equal to the principal amount borrowed; and (c) ask the United States Department of Education to include all terms of Public Service Loan Forgiveness in the contractual obligations of the Master Promissory Note. D-305.993
(d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note;	
(e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer;	11. Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to require programs to include within the terms, conditions, and benefits of appointment to the program (which must be provided to applicants invited to interview, as per ACGME Institutional Requirements) information regarding the Public Service Loan Forgiveness (PSLF) program qualifying status of the employer. D-305.993

Proposed language for adoption	Original language
(f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility;	12. Our AMA will advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility. D-305.993
(g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed;	13. Our AMA encourages medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed. D-305.993
(h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas;	14. Our AMA encourages medical school financial advisors to promote to medical students service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas. D-305.993
(i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.	15. Our AMA will strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes. D-305.993

APPENDIX B: PROPOSED AMA POLICY: “PRINCIPLES OF AND ACTIONS TO ADDRESS MEDICAL EDUCATION COSTS AND STUDENT DEBT” (TEXT VERSION)

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty.

To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs—such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector—to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.

11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to
 - (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education;
 - (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs;
 - (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students;
 - (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students;
 - (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation;
 - (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen;
 - (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees;
 - (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies;
 - (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals:
 - (a) Eliminating the single holder rule;

- (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training;
 - (c) Retaining the option of loan forbearance for residents ineligible for loan deferment;
 - (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”;
 - (e) Including room and board expenses in the definition of tax-exempt scholarship income;
 - (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs;
 - (g) Adding the ability to refinance Federal Consolidation Loans;
 - (h) Eliminating the cap on the student loan interest deduction;
 - (i) Increasing the income limits for taking the interest deduction;
 - (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001;
 - (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating;
 - (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will:
 - (a) Advocate that all resident/fellow physicians have access to PSLF during their training years;
 - (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs;
 - (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed;
 - (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note;
 - (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer;
 - (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility;
 - (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed;
 - (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas;
 - (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

APPENDIX C: AMA POLICIES AND DIRECTIVES PROPOSED FOR RESCISSION

1. *D-305.956, "AMA Participation in Reducing Medical Student Debt"*

Our AMA will explore the feasibility of the development of an affinity program in which student, resident and fellow members of our AMA could obtain new educational loans and consolidate existing loans from one or more national banks or other financial intermediaries. Membership in our AMA would be required during the life of the loan (typically 10 years or more following medical school). Such activities or program would neither result in our AMA becoming subject to regulation as a financial institution nor impair our AMA's ability to continue to be treated as a not-for-profit entity.

Res. 609, A-14; Modified: Speakers Rep., I-15

2. *D-305.957, "Update on Financial Aid Programs"*

Our AMA will: (a) through the advocacy process, explore the possibility of assuring that all resident physicians and fellows have access to the Public Service Loan Forgiveness Program for the time they are in residency and fellowship training; and (b) continue to monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

CME Rep. 1, I-10

3. *D-305.962, "Tax Deductibility of Student Loan Payments"*

Our AMA will draft legislation allowing 100% tax deductibility of student loan interest.

Res. 232, A-09; Reaffirmed in lieu of Res. 225, I-12

4. *D-305.966, "Reinstatement of Economic Hardship Loan Deferment"*

Our AMA will actively work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of post-graduate trainees with educational debt.

Res. 930, I-07; Reaffirmed: BOT Rep. 22, A-17

5. *D-305.970, "Proposed Revisions to AMA Policy on Medical Student Debt"*

Our AMA will:

1. Collaborate, based on AMA policy, with members of the Federation and the medical education community, and with other interested organizations, to achieve the following immediate public- and private-sector advocacy goals:

- (a) Support expansion of and adequate funding for federal scholarship and loan repayment programs, such as those from the National Health Service Corps, the Indian Health Service, the Armed Forces, and the Department of Veterans Affairs, and for comparable programs at the state level.
- (b) Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
- (c) With each reauthorization of the Higher Education Act and at every other legislative opportunity, proactively pursue loan consolidation terms that favor students and ensure that loan deferment is available for the entire duration of residency and fellowship training.

- (d) Ensure that the Higher Education Act and other legislation allow interest from medical student loans to be fully tax deductible.
 - (e) Encourage medical schools, with the support of the Federation, to engage in fundraising activities devoted to increasing the availability of scholarship support.
 - (f) Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
 - (g) Support stable funding for medical education programs to limit excessive tuition increases.
2. Encourage medical schools to study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, combined baccalaureate/MD programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education.
- CME Rep. 13, A-06; Reaffirmation I-08

6. *D-305.975, "Long-Term Solutions to Medical Student Debt"*

Our AMA will:

- (1) encourage medical schools and state medical societies to consider the creation of self-managed, low-interest loan programs for medical students, and collect and disseminate information on such programs;
 - (2) advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas;
 - (3) work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment;
 - (4) collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided; and
 - (5) encourage the National Health Services Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
- CME Rep. 3, I-04; Reaffirmation I-06; Appended: Res. 321, A-12; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation I-14

7. *D-305.977, "Deductibility of Medical Student Loan Interest"*

Our AMA will work toward 100% tax deductibility of medical student loan interest on federal and state income tax returns.

Res. 705, I-04; Reaffirmed: CME Rep. 2, A-14

8. *D-305.978, "Mechanisms to Reduce Medical Student Debt"*

Our AMA will:

- (1) take an active advocacy role during the upcoming reauthorization of the Higher Education Act and other pending legislation, to achieve the following goals:
 - (a) eliminating the single holder rule,
 - (b) making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training,

- (c) retaining the option of loan forbearance for residents ineligible for loan deferment,
 - (d) including, explicitly, dependent care expenses in the definition of the “cost of attendance,”
 - (e) including room and board expenses in the definition of tax-exempt scholarship income,
 - (f) continuing the loan consolidation program, including the ability to “lock in” a fixed interest rate, and
 - (g) adding the ability to refinance Federal Consolidation Loans;
 - (2) continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases;
 - (3) encourage members of the Federation to develop or enhance financial aid opportunities for medical students;
 - (4) continue to monitor the availability of financial aid opportunities and financial planning/debt management counseling at medical schools, and share innovative approaches with the medical education community;
 - (5) continue to collect and disseminate information to assist members of the Federation (state medical societies and specialty societies) and medical schools to establish or expand financial aid programs; and
 - (6) continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students.
- CME Rep. 10, A-04; Reaffirmation I-08

9. *D-305.979, “State and Local Advocacy on Medical Student Debt”*

Our AMA will: (1) support and encourage our state medical societies to support further expansion of state loan repayment programs, and in particular expansion of those programs to cover physicians in non-primary care specialties; and

(2) urge state medical societies to actively solicit funds (either directly or through their Foundations) for the establishment and expansion of medical student scholarships, and that our AMA develop a set of guidelines and suggestions to assist states in carrying out such initiatives.

Res. 847, I-03; Reaffirmation A-13; Modified: CME Rep. 2, A-13

10. *D-305.980, “Immediate Legislative Solutions to Medical Student Debt”*

Our AMA will:

- (1) endorse and actively lobby for the Reauthorization of the Higher Education Act, including:
 - (a) Elimination of the “single-holder” rule;
 - (b) Continuation of the consolidation loan program and a consolidator’s ability to lock in a fixed interest rate;
 - (c) Expansion of the deferment period for loan repayment to cover the entire duration of residency and fellowship;
 - (d) Broadening of the definition of economic hardship as used to determine eligibility for student loan deferment;
 - (e) Retention of the option of loan forbearance for residents who are ineligible for student loan deferment; and
 - (f) Inclusion of dependent care expenses in the definition of “cost of attendance”; and
- (2) lobby for passage of legislation that would:
 - (a) Eliminate the cap on the student loan interest deduction;
 - (b) Increase the income limits for taking the interest deduction;
 - (c) Include room and board expenses in the definition of tax-exempt scholarship income; and

(d) Make permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001.
Res. 850, I-03; Reaffirmation I-08

11. D-305.981, "Financing Federal Consolidation Loans"

Our AMA will: (1) support the refinancing of Federal Consolidation Loans; and (2) actively advocate for modification of pending and future legislation which that provides the opportunity to refinance Federal Consolidation Loans.
Res. 849, I-03; Reaffirmed: BOT Rep. 28, A-13

12. D-305.993, "Medical School Financing, Tuition, and Student Debt"

1. The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of developing web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection, loan repayment programs, and a rotating loan program; and creating an AMA scholarship program funded through philanthropy. The AMA also should collect and disseminate information on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other purposes.
2. Our AMA will vigorously advocate for ongoing, adequate funding for federal and state programs that provide scholarship or loan repayment funds in return for service, including funding in return for practice in underserved areas, participation in the military, and participation in academic medicine or clinical research. Obtaining adequate support for the National Health Service Corps and similar programs, tied to the demand for participation in the programs, should be a focus for AMA advocacy efforts.
3. Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
4. Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students.
5. Our AMA supports a requirement that medical schools inform students of all government loan opportunities and requires disclosure of reasons that preferred lenders were chosen.
6. Our AMA will urge the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements to include a requirement that financial planning/debt management counseling be provided for resident physicians.
7. Our AMA will work with other organizations, including the Association of American Medical Colleges, residency program directors groups, and members of the Federation, to develop and disseminate standardized information, for example, computer-based modules, on financial planning/debt management for use by medical students, resident physicians, and young physicians.
8. Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of increasing loan deferment through the period of residency, promoting the expansion of subsidized loan programs, eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans.
9. Our AMA will advocate against putting a monetary cap on federal loan forgiveness programs.
10. Our AMA will: (a) advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; (b) work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be at least equal to the principal amount borrowed; and (c) ask the United States Department of Education to include all terms of Public Service Loan Forgiveness in the contractual obligations of the Master Promissory Note.

11. Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to require programs to include within the terms, conditions, and benefits of appointment to the program (which must be provided to applicants invited to interview, as per ACGME Institutional Requirements) information regarding the Public Service Loan Forgiveness (PSLF) program qualifying status of the employer.

12. Our AMA will advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility.

13. Our AMA encourages medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.

14. Our AMA encourages medical school financial advisors to promote to medical students service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.

15. Our AMA will strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

CME Rep. 2, I-00; Reaffirmation I-03; Reaffirmation I-06; Reaffirmation A-13; Appended: Res. 323, A-14; Appended: Res. 324, A-15; Appended: Res. 318, A-16; Appended: CME Rep. 07, A-17; Modified: CME Rep. 01, A-18.

13. D-405.986, "Student Loans and Medicare / Medicaid Participation"

Our AMA will seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt.

Res. 203, I-12

14. H-305.926, "Supporting Legislation to Create Student Loan Savings Accounts"

Our AMA will advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

Res. 202, A-16

15. H-305.928, "Proposed Revisions to AMA Policy on Medical Student Debt"

1. Our AMA will make reducing medical student debt a high priority for legislative and other action and will collaborate with other organizations to study how costs to students of medical education can be reduced.

2. Our AMA supports stable funding for medical schools to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue and should oppose mid-year and retroactive tuition increases.

3. Financial aid opportunities, including scholarship and loan repayment programs, should be available so that individuals are not denied an opportunity to pursue medical education because of financial constraints.

4. A sufficient breadth of financial aid opportunities should be available so that student specialty choice is not constrained based on the need for financial assistance.

5. Our AMA supports the creation of new and the expansion of existing medical education financial assistance programs from the federal government, the states, and the private sector.

6. Medical schools should have programs in place to assist students to limit their debt. This includes making scholarship support available, counseling students about financial aid availability, and providing comprehensive debt management/financial planning counseling.

7. Our AMA supports legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit the full deductibility of interest on student loans.

8. Medical students should not be forced to jeopardize their education by the need to seek employment. Any decision on the part of the medical student to seek employment should take into account his/her academic situation. Medical schools should have policies and procedures in place that allow for flexible scheduling in the case that medical students encounter financial difficulties that can be remedied only by employment. Medical schools should consider creating opportunities for paid employment for medical students.

9. Financial obligations, such as repayment of loans, and service obligations made in exchange for financial assistance, should be fulfilled. There should be mechanisms to assist physicians who are experiencing hardship in meeting these obligations.

10. Our AMA supports the expansion and increase of medical student and physician benefits under Public Service Loan Forgiveness.

11. Our AMA opposes any stipulations in loan repayment programs that place greater burdens upon married couples than for similarly-situated couples who are cohabitating.

CME Rep. 13, A-06; Reaffirmation I-06; Reaffirmation I-07; Reaffirmation I-08; Reaffirmed: CME Rep. 8, A-12; Reaffirmation A-13; Appended: Res. 304, A-13; Appended: Res. 323, A-15; Reaffirmation I-15

16. H-305.932, "State and Local Advocacy on Medical Student Debt"

Our AMA:

(1) opposes the charging of broad and ill-defined student fees by medical schools, such as but not limited to professional fees, encouraging in their place fees that are earmarked for specific and well-defined purposes;

(2) encourages medical schools to use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; and

(3) encourages medical schools to cooperate with undergraduate institutions to establish collaborative debt counseling for entering first-year medical students.

Res. 847, I-03; Reaffirmed: CME Rep. 2, A-13

17. H-305.948, "Direct Loan Consolidation Program"

The AMA supports the Individual Education Account/Direct Loan Consolidation Program.

Res. 312, I-95; Reaffirmed: CME Rep. 2, A-05; Reaffirmed: CME Rep. 1, A-15

18. H-305.954, "Repayment of Medical School Loans"

Our AMA will further develop and more aggressively publicize a low interest rate and extended payment loan program for young physician members of the AMA to assist them in retiring their educational debts.

CME Rep. O, A-93; Appended: Res. 610, I-98; Modified: CME Rep. 13, A-06; Modified: CME Rep. 01, A-16

19. H-305.965, "Student Loans"

Our AMA: (1) reaffirms its support of legislation that would defer the repayment of loans for education until the completion of residency training; and
(2) will lobby for deferment of medical student loans for the full initial residency period.
Sub. Res. 203, A-90; Appended Res. 306, I-99; Reaffirmation A-01; Reaffirmation I-06; Modified: CME Rep 01, A-16

20. H-305.980, "Student Loan Repayment Grace Period"

The AMA supports giving consideration to grace periods in renewals of federal loan programs and attempting to secure the most favorable repayment terms.
CME Rep. I, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, I-00; Reaffirmed: CME Rep. 2, A-10

21. H-305.991, "Repayment of Educational Loans"

The AMA (1) believes that it is improper for any physician not to repay his or her educational loans;
(2) urges increased efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students; and
(3) encourages medical school financial aid officers to counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation.
Sub. Res. 47, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05;
Reaffirmed: CME Rep. 1, A-15

APPENDIX D: PORTIONS OF AMA POLICIES AND DIRECTIVES THAT ARE NOT BEING RETAINED THROUGH THIS REPORT

Language	Rationale for removal
<p>H-305.954: Our AMA will further develop and more aggressively publicize a low interest rate and extended payment loan program for young physician members of the AMA to assist them in retiring their educational debts.</p>	<p>Accomplished through AMA affinity partnership programs (Credible and Laurel Roads).</p>
<p>H-305.980: The AMA supports giving consideration to grace periods in renewals of federal loan programs and attempting to secure the most favorable repayment terms.</p>	<p>The first phrase, “giving consideration to grace periods in renewals of federal loan programs,” has been integrated into the new policy. The second phrase, “attempting to secure the most favorable repayment terms,” has been accomplished through the AMA affinity partnership programs (Credible and Laurel Roads).</p>
<p>D-305.993: 1. The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of developing web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection, loan repayment programs, and a rotating loan program; and creating an AMA scholarship program funded through philanthropy. The AMA also should collect and disseminate information on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other purposes.</p>	<ul style="list-style-type: none"> • Through an AMA affinity program, AMA members can obtain discounts on refinancing student loans. https://www.ama-assn.org/content/ama-preferred-provider-offers-and-services-loans-and-financial-services • The AMA Career Planning Resource offers budget planning tools: https://www.ama-assn.org/life-career/career-planning-resource. Evaluation of the feasibility of further tools has been accomplished. • The AMA Foundation provides student scholarships, as well as the AMA Employee-funded scholarship
<p>D-305.956: Our AMA will explore the feasibility of the development of an affinity program in which student, resident and fellow members of our AMA could obtain new educational loans and consolidate existing loans from one or more national banks or other financial intermediaries. Membership in our AMA would be required during the life of the loan (typically 10 years or more following medical school). Such activities or program would neither result in our AMA becoming subject to regulation as a financial institution nor impair our AMA's ability to continue to be treated as a not-for-profit entity.</p>	<p>Accomplished through AMA affinity partnership programs (Credible and Laurel Roads).</p>

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-I-18

Subject: Reconciliation of AMA Policy on Resident/Fellow Contracts and Duty Hours

Presented by: Carol Berkowitz, MD, Chair

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

INTRODUCTION

The goal of this report is to review, reconcile, and consolidate existing American Medical Association (AMA) policy on resident/fellow contracts and duty hours, eliminate duplication, and ensure that current policies are coherent and relevant. For each policy recommendation, a succinct but cogent justification is provided to support the proposed action. The most recent policy was deemed to supersede contradictory past AMA policies, and the language of each proposed policy was edited so that it is coherent and easily understood, without altering its meaning or intent.

POLICIES INCLUDED IN THIS REPORT

The following AMA policies are addressed in this report:

1. D-310.987, "Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety"
2. H-310.907, "AMA Duty Hours Policy"
3. H-310.912, "Residents and Fellows' Bill of Rights"
4. H-310.922, "Determining Residents' Salaries"
5. H-310.929, "Principles for Graduate Medical Education"
6. H-310.932, "Annual Contracts for Continuing Residents"
7. H-310.947, "Revision of the 'General Requirements' of the Essentials of Accredited Residency Programs"
8. H-310.979, "Resident Physician Working Hours and Supervision"
9. H-310.988, "Adequate Resident Compensation"
10. H-310.999, "Guidelines for Housestaff Contracts or Agreements"

SUMMARY AND RECOMMENDATIONS

This report encompasses a review of current AMA policies on resident/fellow contracts and duty hours to ensure such policy is consistent, accurate, and up-to-date. Three of the 10 policies being addressed in this report are recommended for revision, as shown in Appendix A, with a clean text version shown in Appendix B:

- H-310.907, "AMA Duty Hours Policy"
- H-310.912, "Residents and Fellows' Bill of Rights"
- H-310.929, "Principles for Graduate Medical Education"

Appendix C lists the seven remaining policies that are proposed for rescission. Relevant aspects of the following four of these seven policies are recommended for a) incorporation into the three policies above and b) rescission:

- D-310.987, “Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety”
- H-310.922, “Determining Residents’ Salaries”
- H-310.947, “Revision of the ‘General Requirements’ of the Essentials of Accredited Residency Programs”
- H-310.979, “Resident Physician Working Hours and Supervision”

The remaining three policies being treated in this report are recommended for rescission and are not being retained in the three revised policies, as they are superseded by or already reflected in existing AMA policy:

- H-310.932, “Annual Contracts for Continuing Residents”
- H-310.988, “Adequate Resident Compensation”
- H-310.999, “Guidelines for Housestaff Contracts or Agreements”

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

1. That our American Medical Association (AMA) adopt the proposed revisions shown in Appendix A, column 1, for the following three policies:

- 1) H-310.907, “AMA Duty Hours Policy” (with revised title: “Resident/Fellow Clinical and Educational Work Hours”)
- 2) H-310.912, “Residents and Fellows’ Bill of Rights”
- 3) H-310.929, “Principles for Graduate Medical Education”
(Modify Current HOD Policy)

2. That our AMA rescind the following seven policies, as shown in Appendix C, and incorporate relevant portions of four of these policies into existing AMA policy:

- 1) D-310.987, “Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety”
- 2) H-310.922, “Determining Residents’ Salaries”
- 3) H-310.932, “Annual Contracts for Continuing Residents”
- 4) H-310.947, “Revision of the ‘General Requirements’ of the Essentials of Accredited Residency Programs”
- 5) H-310.979, “Resident Physician Working Hours and Supervision”
- 6) H-310.988, “Adequate Resident Compensation”
- 7) H-310.999, “Guidelines for Housestaff Contracts or Agreements”
(Rescind HOD Policy)

Fiscal note: \$1,000.

APPENDIX A: PROPOSED REVISIONS TO THREE AMA POLICIES RELATED TO
RESIDENT/FELLOW CONTRACTS AND DUTY HOURS (WORKSHEET VERSION)

Note: The right column shows the original language; the left column shows the recommended action and any edits to the original language.

H-310.907, “AMA duty hours policy”

Proposed language for adoption	Original language
<i>Note: Revise title of policy and aspects of policy as noted below, to reflect 2018 terminology from the Accreditation Council for Graduate Medical Education (ACGME), with “duty hours” replaced by “clinical and educational work hours.”</i>	
Policy Title: AMA duty hours policy <u>Resident/Fellow Clinical and Educational Work Hours</u>	Policy Title: AMA duty hours policy
Our AMA adopts the following Principles of Resident/Fellow Duty Hours <u>Clinical and Educational Work Hours</u> , Patient Safety, and Quality of Physician Training:”	Our AMA adopts the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training:
1. Our AMA reaffirms supports of the 2003 <u>2017</u> Accreditation Council for Graduate Medical Education (ACGME) duty hour standards <u>for clinical and educational work hours</u> (previously referred to as “duty hours”).	1. Our AMA reaffirms support of the 2003 Accreditation Council for Graduate Medical Education (ACGME) duty hour standards. <i>(Note: The 2003 standards have been superseded by the 2017 standards.)</i>
2. Our AMA will continue to monitor the enforcement and impact of duty <u>clinical and educational work</u> hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.	2. Our AMA will continue to monitor the enforcement and impact of duty hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty <u>clinical and educational work</u> hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.	3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of duty <u>clinical and educational work</u> hour requirements and, pending the outcomes of	4. Our AMA endorses the study of innovative models of duty hour requirements and, pending the outcomes of ongoing and future research,

Proposed language for adoption	Original language
ongoing and future research, should consider the evolution of specialty- and rotation-specific duty hours requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.	should consider the evolution of specialty- and rotation-specific duty hours requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:	<i>(unchanged)</i>
a) Decrease the barriers to reporting of both duty <u>clinical and educational work</u> hour violations and resident intimidation.	a) Decrease the barriers to reporting of both duty hour violations and resident intimidation.
b) Ensure that readily accessible, timely and accurate information about duty <u>clinical and educational work</u> hours is not constrained by the cycle of ACGME survey visits.	b) Ensure that readily accessible, timely and accurate information about duty hours is not constrained by the cycle of ACGME survey visits.
c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of resident-duty <u>clinical and educational work</u> hour rules.	c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of resident duty hour rules.
d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of duty <u>clinical and educational work</u> hours.	d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of duty hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:	<i>(unchanged)</i>
a) Offer incentives to programs/institutions to ensure compliance with duty <u>clinical and educational work</u> hour standards.	a) Offer incentives to programs/institutions to ensure compliance with duty hour standards.
b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.	<i>(unchanged)</i>
c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.	<i>(unchanged)</i>
d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.	<i>(unchanged)</i>
7. Our AMA supports the following statements related to duty <u>clinical and educational work</u> hours:	7. Our AMA supports the following statements related to duty hours:
a) Resident physician <u>Total duty clinical and educational work</u> hours must not exceed 80	a) Resident physician total duty hours must not exceed 80 hours per week, averaged over a four-

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hours per week, averaged over a four-week period (Note: “Total <u>duty clinical and educational work</u> hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).	week period (Note: “Total duty hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.	<i>(unchanged)</i>
c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.	<i>(unchanged)</i>
d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.	<i>(unchanged)</i>
e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”	<i>(unchanged)</i>
f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, <u>duty clinical and educational work</u> hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, to the 16-hour shift limit for first-year residents , or allowing a limited increase to the total number of <u>duty clinical and educational work</u> hours when need is demonstrated.	f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, duty hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, to the 16-hour shift limit for first-year residents, or allowing a limited increase to the total number of duty hours when need is demonstrated.

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g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.	<i>(unchanged)</i>
h) Duty <u>Clinical and educational work</u> hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total duty <u>clinical and educational work</u> hour limits for all resident physicians.	h) Duty hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total duty hour limits for all resident physicians.
i) Scheduled time providing patient care services of limited or no educational value should be minimized.	<i>(unchanged)</i>
j) Accurate, honest, and complete reporting of resident duty <u>clinical and educational work</u> hours is an essential element of medical professionalism and ethics.	j) Accurate, honest, and complete reporting of resident duty hours is an essential element of medical professionalism and ethics.
k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of duty <u>clinical and educational work</u> hour regulations, and opposes any regulatory or legislative proposals to limit the duty work hours of practicing physicians.	k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of duty hour regulations, and opposes any regulatory or legislative proposals to limit the duty hours of practicing physicians.
l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.	<i>(unchanged)</i>
m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.	<i>(unchanged)</i>
n) The costs of duty <u>clinical and educational work</u> hour limits should be borne by all health	n) The costs of duty hour limits should be borne by all health care payers.

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care payers. <u>Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.</u>	(j) Individual resident compensation and benefits must not be compromised or decreased as a result of these recommended changes in the graduate medical education system. H-310.979
o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.	<i>(unchanged)</i>
8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.	<i>(unchanged)</i>
<u>9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians.</u>	Our American Medical Association will actively participate in ongoing efforts to monitor the impact of resident duty hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians. D-310.987
CME Rep. 5, A-14	

H-310.912, “Residents and Fellows’ Bill of Rights”

Proposed language for adoption	Original language
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.	<i>(unchanged)</i>
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.	<i>(unchanged)</i>
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this Residents and Fellow Physicians’ Bill of Rights.	3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this Residents and Fellows’ Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution’s process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or	<i>(unchanged)</i>

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within one month of document submission is strongly recommended.	
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.	<i>(unchanged)</i>
6. Our AMA adopts the following ‘Residents and Fellows’ Bill of Rights’ as applicable to all resident and fellow physicians in ACGME-accredited training programs:	<i>(unchanged)</i>
RESIDENTS AND FELLOW PHYSICIANSs’ BILL OF RIGHTS	RESIDENTS AND FELLOWS’ BILL OF RIGHTS
Residents and fellows have a right to:	<i>(unchanged)</i>
A. An education that fosters professional development, takes priority over service, and leads to independent practice.	<i>(unchanged)</i>
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.	<i>(unchanged)</i>
B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.	<i>(unchanged)</i>
With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience.	With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience.

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<p><u>It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.</u></p>	<p>(i) Is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. As stated in the ACGME Common Program Requirements (VI.B) “the program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.” H-310.979</p>
<p>C. Regular and timely feedback and evaluation based on valid assessments of resident performance.</p>	<p><i>(unchanged)</i></p>
<p>With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.</p>	<p><i>(unchanged)</i></p>
<p>D. A safe and supportive workplace with appropriate facilities.</p>	<p><i>(unchanged)</i></p>
<p>With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.</p>	<p><i>(unchanged)</i></p>
<p>E. Adequate compensation and benefits that provide for resident well-being and health.</p>	<p><i>(unchanged)</i></p>
<p>(1) With regard to contracts, residents and fellows should receive: a. Information about the</p>	<p><i>(unchanged)</i></p>

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<p>interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.</p>	
<p>(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience; <u>Compensation should and that reflect cost of living differences based on geographical differences, local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.</u></p>	<p>(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience, and that reflect cost of living differences based on geographical differences.</p> <p>Our AMA encourages teaching institutions to base residents' salaries on the resident's level of training as well as local economic factors, such as housing, transportation, and energy costs, that affect the purchasing power of wages, with appropriate adjustments for changes in cost of living.</p> <p>H-310.922</p>
<p>(3) With Regard to Benefits, Residents and Fellows <u>Must Be Fully Informed of and Should Receive:</u> a. Quality and affordable comprehensive medical, mental health, dental, and vision care <u>for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program;</u> b. <u>An institutional written policy on and e</u>Education on <u>in</u> the signs of excessive fatigue, clinical depression, and substance abuse and dependence, <u>and other physician impairment issues;</u> c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined</p>	<p>(3) With Regard to Benefits, Residents and Fellows Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care; b. Education on the signs of excessive fatigue, clinical depression, and substance abuse and dependence; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and paternity leave and educational leave during each year in their training program the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act.</p>

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<p>amount of paid vacation leave, sick leave, maternity and paternity family and medical leave and educational/<u>professional</u> leave during each year in their training program, the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act-; <u>and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.</u></p>	<p>The AMA supports the following principles of the ACGME Institutional Requirements: Candidates for residencies must be fully informed of benefits including financial support, vacations, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance, and other insurance benefits for the residents and their family and the conditions under which living quarters, meals and laundry or their equivalent are to be provided. Institutions sponsoring graduate medical education must provide access to insurance, where available, to all residents for disabilities resulting from activities that are part of the educational program. Institutions should have a written policy and an educational program regarding physician impairment, including substance abuse.</p> <p>H-310.947</p>
<p>F. Duty <u>Clinical and educational work</u> hours that protect patient safety and facilitate resident well-being and education.</p>	<p>F. Duty hours that protect patient safety and facilitate resident well-being and education.</p>
<p>With regard to duty <u>clinical and educational work</u> hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with duty-clinical and educational work hour requirements set forth by the ACGME or other relevant accrediting body; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that duty-clinical and educational work hour requirements are effectively circumvented. <u>Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.</u></p>	<p>With regard to duty hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with duty-hour requirements set forth by the ACGME or other relevant accrediting body; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that duty-hour requirements are effectively circumvented.</p>
<p>G. Due process in cases of allegations of misconduct or poor performance.</p>	<p>(unchanged)</p>
<p>With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.</p>	<p>(unchanged)</p>
<p>H. Access to and protection by institutional and accreditation authorities when reporting violations.</p>	<p>(unchanged)</p>

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<p>With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.</p>	<p><i>(unchanged)</i></p>
<p>CME Rep. 8, A-11 Appended: Res. 303, A-14 Reaffirmed: Res. 915, I-15 Appended: CME Rep. 04, A-16</p>	

H-310.929, "Principles for Graduate Medical Education"

Proposed language for adoption	Original language
Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in the revised "its Institutional Requirements" of the Essentials of Accredited Residencies of Graduate Medical Education , if they are not already present.	Our AMA urges the Accreditation Council for Graduate Medical Education to incorporate these principles in the revised "Institutional Requirements" of the Essentials of Accredited Residencies of Graduate Medical Education, if they are not already present.
<p>(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.</p> <p><u>Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.</u></p>	<p>(1) PURPOSE OF GRADUATE MEDICAL EDUCATION. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.</p> <p>(a) Exemplary patient care is a vital component for any program of graduate medical education. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited residency program. Graduate medical education must never compromise the quality of patient care.</p> <p>(b) Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.</p> <p>H-310.979</p>
(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.	(unchanged)
(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.	(unchanged)
(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities	(unchanged)

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<p>and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.</p>	
<p>(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.</p>	<p><i>(unchanged)</i></p>
<p>(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education <u>accreditation requirements of the ACGME</u>, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow</p>	<p>(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or</p>

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residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.	similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.
(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.	<i>(unchanged)</i>
(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the “Program Requirements.” The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician’s education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.	<i>(unchanged)</i>
(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.	<i>(unchanged)</i>
(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and	<i>(unchanged)</i>

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information systems, and population-based medicine should be included as appropriate to the specialty.	
(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.	<i>(unchanged)</i>
(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise <u>and evaluate</u> the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, <u>and specified in the ACGME Institutional Requirements and related accreditation documents,</u> must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician <u>and the level of responsibility for the care of patients that may be safely delegated to the resident.</u> <u>The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible</u>	(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows.

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<p><u>for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards.</u> Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. <u>Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.</u></p>	<p>(c) Institutional commitment to graduate medical education must be evidenced by compliance with Section III.B.4 of the ACGME Institutional Requirements, effective July 1, 2007: The sponsoring institution's GME Committee must [m]onitor programs' supervision of residents and ensure that supervision is consistent with: (i) Provision of safe and effective patient care; (ii) Educational needs of residents; (iii) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (iv) Other applicable Common and specialty/subspecialty specific Program Requirements.</p> <p>(d) The program director must be responsible for the evaluation of the progress of each resident and for the level of responsibility for the care of patients that may be safely delegated to the resident.</p> <p>(e) Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.</p> <p>(f) The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with Residency Review Committee (RRC) recommendations, and in compliance with the ACGME duty hour standards.</p> <p>H-310.979</p>
<p>(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board</p>	<p>(unchanged)</p>

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<p>certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.</p>	
<p>(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.</p>	(unchanged)
<p>(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.</p>	(unchanged)
CME Rep. 9, A-99 Reaffirmed: CME Rep. 2, A-09 Reaffirmed: CME Rep. 14, A-09	

APPENDIX B: PROPOSED REVISIONS TO THREE AMA POLICIES RELATED TO
RESIDENT/FELLOW CONTRACTS AND DUTY HOURS (CLEAN TEXT VERSION)

H-310.907, “Resident/Fellow Clinical and Educational Work Hours”

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:”

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as “duty hours”).
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
 - a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
 - b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
 - c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
 - d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
 - a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.

- b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
 - c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
 - d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
- a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: “Total clinical and educational work hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
 - b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.
 - c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
 - d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
 - e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”
 - f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
 - g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.

- h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
 - i) Scheduled time providing patient care services of limited or no educational value should be minimized.
 - j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
 - k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.
 - l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
 - m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
 - n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.
 - o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.
8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.
9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

H-310.912, "Residents and Fellows' Bill of Rights"

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.
6. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that

minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

H-310.929, "Principles for Graduate Medical Education"

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.

(1) **PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE.** There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.

(2) **RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING.** Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) **EDUCATION IN THE BROAD FIELD OF MEDICINE.** GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) **SCHOLARLY ACTIVITIES FOR RESIDENTS.** Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) **FACULTY SCHOLARSHIP.** All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) **INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS.** Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the

affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) **COMPENSATION OF RESIDENT PHYSICIANS.** All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) **LENGTH OF TRAINING.** The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) **PROVISION OF FORMAL EDUCATIONAL EXPERIENCES.** Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) **INNOVATION OF GRADUATE MEDICAL EDUCATION.** The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) **THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION.** Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) **SUPERVISION OF RESIDENT PHYSICIANS.** Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the

ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

APPENDIX C: AMA POLICIES AND DIRECTIVES PROPOSED FOR RESCISSION

Note: The following seven policies are recommended for rescission. The original language is shown in the left column; the rationale for rescission is in the right column.

D-310.987, “Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety”

Original language	Rationale for rescission
Our American Medical Association will actively participate in ongoing efforts to monitor the impact of resident duty hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians.	Still relevant, but rescind and append to H-310.907 (9), “AMA duty hours policy.”
Res. 314, A-03 Reaffirmation A-12	

H-310.922, “Determining Residents’ Salaries”

Original language	Rationale for rescission
Our AMA encourages teaching institutions to base residents’ salaries on the resident’s level of training as well as local economic factors, such as housing, transportation, and energy costs, that affect the purchasing power of wages, with appropriate adjustments for changes in cost of living.	Still relevant, but rescind and incorporate into H-310.912 (E.2), “Residents and Fellows’ Bill of Rights.”
Res. 303, A-06 Modified: CME Rep. 04, A-16	

H-310.932, “Annual Contracts for Continuing Residents”

Original language	Rationale for rescission
Our AMA urges the ACGME to require resident training programs to provide their residents with notice of non-renewal of contracts no later than four months prior to the end of their contract.	Still relevant, but rescind; already reflected in H-310.912 (E), “Residents and Fellows’ Bill of Rights,” as follows: “(1) With regard to contracts, residents and fellows should receive: ... b. At least four months advance notice of contract non-renewal and the reason for non-renewal.”
Sub. Res. 310, A-99 Reaffirmed: CME Rep. 2, A-09	

H-310.947, “Revision of the ‘General Requirements’ of the Essentials of Accredited Residency Programs”

Original language	Rationale for rescission
The AMA supports the following principles of the ACGME Institutional Requirements: Candidates for residencies must be fully informed of benefits including financial support,	Still relevant, but rescind and incorporate into H-310.912 (E.3), “Residents and Fellows’ Bill of Rights.”

vacations, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance, and other insurance benefits for the residents and their family and the conditions under which living quarters, meals and laundry or their equivalent are to be provided. Institutions sponsoring graduate medical education must provide access to insurance, where available, to all residents for disabilities resulting from activities that are part of the educational program. Institutions should have a written policy and an educational program regarding physician impairment, including substance abuse.	Note: This policy is also reflected in ACGME Institution Requirements, effective July 1, 2018, under IV.A.3., III.B.7.b), and IV.B.
CME Rep. Q, A-93 Modified: CME Rep. 2, A-03 Reaffirmed: CME Rep. 2, A-13	

H-310.979, “Resident Physician Working Hours and Supervision”

Original language	Rationale for rescission
(1) Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress:	Still relevant, but rescind and incorporate relevant aspects into other policies, as noted below.
(a) Exemplary patient care is a vital component for any program of graduate medical education. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited residency program. Graduate medical education must never compromise the quality of patient care.	Incorporate into H-310.929 (1), “Principles for Graduate Medical Education.”
(b) Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program’s educational objectives for the residents.	

Original language	Rationale for rescission
<p>(c) Institutional commitment to graduate medical education must be evidenced by compliance with Section III.B.4 of the ACGME Institutional Requirements, effective July 1, 2007: The sponsoring institution's GME Committee must [m]onitor programs' supervision of residents and ensure that supervision is consistent with: (i) Provision of safe and effective patient care; (ii) Educational needs of residents; (iii) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (iv) Other applicable Common and specialty/subspecialty specific Program Requirements.</p> <p>(d) The program director must be responsible for the evaluation of the progress of each resident and for the level of responsibility for the care of patients that may be safely delegated to the resident.</p> <p>(e) Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.</p> <p>(f) The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with Residency Review Committee (RRC) recommendations, and in compliance with the ACGME duty hour standards.</p>	<p>Incorporate relevant aspects into H-310.929 (12), "Principles for Graduate Medical Education."</p>
<p>(g) The program director, with institutional support, must assure for each resident effective counseling as stated in Section II.D.4.k of the Institutional requirements: "Counseling services: The Sponsoring Institution should facilitate residents' access to confidential counseling, medical, and psychological support services."</p>	<p>Rescind; already reflected in H-295.858, "Access to Confidential Health Services for Medical Students and Physicians," as follows:</p> <p>"A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an</p>

Original language	Rationale for rescission
	external site, or through telemedicine or other virtual, online means.”
(h) As stated in the ACGME Institutional Requirements (II.F.2.a-c), “The Sponsoring Institution must provide services and develop health care delivery systems to minimize residents’ work that is extraneous to their GME programs’ educational goals and objectives.” These include patient support services, laboratory/pathology/radiology services, and medical records.	<p>Rescind; already reflected in H-310.912 (A), “Residents and Fellows’ Bill of Rights,” as follows:</p> <p>“With regard to education, residents and fellows should expect: . . . (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value.”</p> <p>Also reflected in H-310.907 (7), “AMA duty hours policy,” as follows:</p> <p>“i) Scheduled time providing patient care services of limited or no educational value should be minimized.”</p>
(i) Is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. As stated in the ACGME Common Program Requirements (VI.B) “the program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.”	Incorporate into H-310.912 (B), “Residents and Fellows’ Bill of Rights.”
(j) Individual resident compensation and benefits must not be compromised or decreased as a result of these recommended changes in the graduate medical education system.	Incorporate into H-310.907 (7.n), “AMA duty hours policy.”
(2) These problems should be addressed within the present system of graduate medical education, without regulation by agencies of government.	<p>Rescind; already reflected in H-310.907 (7), “AMA duty hours policy,” as follows:</p> <p>“k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of duty hour regulations, and opposes any regulatory or legislative proposals to limit the duty hours of practicing physicians.”</p>
CME Rep. C, I-87; Modified: Sunset Report, I-97; Modified and Reaffirmed: CME Rep. 2, A-08	

H-310.988, "Adequate Resident Compensation"

Original language	Rationale for rescission
The AMA believes that housestaff should receive adequate compensation by their training programs.	Still relevant, but rescind; already reflected in H-310.912 (E.2), "Residents and Fellows' Bill of Rights," and H-310.929 (7), "Principles for Graduate Medical Education."
Sub. Res. 124, A-85 Reaffirmed by CLRPD Rep. 2, I-95 Reaffirmed: CME Rep. 2, A-05 Reaffirmed: CME Rep. 1, A-15	

H-310.999, "Guidelines for Housestaff Contracts or Agreements"

Original language	Rationale for rescission
The "Essentials of Approved Residencies," approved by the House of Delegates in 1970, includes a section on relationships of housestaff and institutions. The following outline is intended to promote additional guidance to all parties in establishing the conditions under which house officers learn and provide services to patients.	Rescind; superseded by more recent AMA policy, including H-310.929, "Principles for Graduate Medical Education," H-310.912, "Residents and Fellows' Bill of Rights," H-225.950, "AMA Principles for Physician Employment," Code of Medical Ethics 9.2.4, "Disputes Between Medical Supervisors & Trainees," H-225.942, "Physician and Medical Staff Member Bill of Rights," along with the AMA Annotated Model Physician-Hospital Employment Agreement and AMA Annotated Model Physician-Group Practice Employment Agreement (see https://www.ama-assn.org/life-career/understanding-employment-contracts).
Training programs have been central to the process of graduate medical education which has produced a high level of medical competence in the United States. The American Medical Association recognizes that the integrity of these programs is a primary objective in achieving the best possible care of the patient. It is, therefore, incumbent upon members of the housestaff and the institutions in which they are being trained to be aware of the parameters and responsibilities applicable to their training programs. In the absence of such awareness, unreasonable expectations may arise to threaten the harmony between hospital and housestaff in the performance of their joint mission.	
It should be emphasized that these guidelines are not intended as a fixed formula. Guidelines that seek to cover public, voluntary and proprietary hospitals necessarily entail so many variables from training institution to training institution that no single form of contract or agreement would be universally applicable. This set of guidelines has, therefore, been developed to	

cover the more significant substantive provisions of a housestaff contract or agreement.	
The subjects included in the Guidelines are not intended to be the only subjects important or appropriate for a contract or agreement. Moreover, the definition of the respective responsibilities, rights and obligations of the parties involved can assume various forms: individual contracts or agreements, group contracts or agreements, or as a part of the rules of government of the institution.	
II. Proposed Terms and Conditions A. Parties to the Contract or Agreement (1) Contracts or agreements may be formed between individuals or groups, and institutions. Such a group might be a housestaff organization. (2) The two parties to an agreement or contract may be a single institution or a group of institutions, and an individual member of the housestaff, an informal group of the housestaff, or a formally constituted group or association of the housestaff, as determined by the housestaff organization.	
B. General Principles (1) Contracts or agreements are legal documents and must conform to the laws, rules, and regulation to which the institutions are subject. Position, salary and all other benefits should remain in effect insofar as possible without regard to rotational assignments even when the member of the housestaff is away from the parent institution. Exceptions required by law or regulations should be clearly delineated to the house officer at the time of the appointment. Changes in the number of positions in each year of a training program should be made so as not to affect adversely persons already in, or accepted in, that program. The agreement should provide fair and equitable conditions of employment for all those performing the duties of interns, residents and fellows. When a general contract or agreement is in effect between an association and an institution, individual contracts or agreements should be consistent. (2) Adequate prior notification of either party's intent not to review the contract or agreement should be required, and the date of such notification should be included in the contract or agreement. (3) The institution and the individual members of the housestaff must accept and recognize the right of the housestaff to determine the means by which the housestaff may organize its affairs, and both	

<p>parties should abide by that determination; provided that the inherent right of a member of the housestaff to contract and negotiate freely with the institution, individually or collectively, for terms and conditions of employment and training should not be denied or infringed. No contract should require or prescribe that members of the housestaff shall or shall not be members of an association or union.</p>	
<p>C. Obligation of the Housestaff (1) Members of the housestaff agree to fulfill the educational requirements of the graduate training programs, and accept the obligation to use their efforts to provide safe, effective and compassionate patient care as assigned or required under the circumstances as delineated in the ACGME “Essentials of Approved Residencies” and previously approved standards of the AMA Council on Medical Education. (2) Members of the housestaff should comply with the laws, regulations, and policies to which the institution is subject.</p>	
<p>D. Obligation of the Institution (1) The institution agrees to provide an educational program that meets the standards of the ACGME “Essentials of Approved Residencies.” (2) The institution agrees to maintain continuously its staff and its facilities in compliance with all of the standards in the ACGME “Essentials of Approved Residencies.”</p>	
<p>E. Salary for Housestaff (1) The salary to be paid and the frequency of payment should be specified. The salary schedule should be published. The basis for increments and the time of the increments should be specified. (2) In determining the salary level of a member of the housestaff, prior educational experience should be considered, and a determination made as to whether credit should be given. (3) The responsibilities of senior residents should be recognized in salary differentials.</p>	
<p>F. Hours of Work There should be recognition of the fact that long duty hours extending over an unreasonably long period of time or onerous on-call schedules are not consistent with the primary objective of education or the efficient delivery of optimal patient care. The institution should commit itself to fair scheduling of duty time for all members of</p>	

the housestaff, including the provision of adequate off-duty hours.	
<p>G. Off-Duty Activities The contract or agreement should provide that a member of the housestaff is free to use his off-duty hours as he sees fit, including engaging in outside employment if permitted by the terms of the original contract or agreement, so long as such activity does not interfere with his obligations to the institution or to the effectiveness of the educational program to which he has been appointed.</p>	
<p>H. Vacation and Leave The AMA encourages residency programs across the country to permit and schedule off-duty time separate from personal vacation time to enable residents to attend educational and/or organized medicine conferences. The amount of vacation, sick leave, and educational leave to which each member of the housestaff is entitled should be specified. Vacations should be expressed in terms of customary working days as defined by the institution. If vacations may be taken only at certain times of the year, this restriction should be stated. Any requirements for scheduling vacation time should also be stated. Provisions may also cover leaves for maternity, paternity, bereavement, military duty, examinations and preparations therefor, and educational conferences. Reimbursement for tuition and expenses incurred at educational conferences should be considered. The agreement should set forth any progressive increases in the amount of time allowed for vacation, sick leave, and educational leave. Educational leave should not be deducted from vacation time.</p>	
<p>I. Insurance Benefits Insurance benefits should be set forth with particularity and should be tailored to the specific needs of the housestaff. Some of the more common insurance benefit provisions are (1) hospitalization and basic medical coverage for the member of the housestaff, spouse, and minor children; (2) major medical coverage for the member of the housestaff, spouse, and minor children; and (3) group life insurance, and dismemberment and disability insurance for the member of the housestaff only. It should also be specified whether the institution will pay the full amount of premiums or only a portion of the premiums, the balance to be paid by the member of the housestaff. Co-paid benefits should be</p>	

<p>established, separately from other hospital employee benefits, as a means of maximizing benefits. In some instances, free care for the housestaff and their families at the training institutions may be provided. In lieu of insurance benefits, the contract or agreement may provide for fixed annual payments to a housestaff association for each member of the housestaff so that the housestaff association may determine and provide for insurance or other benefits for the housestaff.</p>	
<p>J. Professional Liability Insurance The contract or agreement should specify the amount of professional liability insurance that the institution will provide for each member of the housestaff together with the limits of liability applicable to such coverage. It might also be appropriate to provide in the contract or agreement that the housestaff and the institution will cooperate fully with the insurance company in the handling of any professional liability claim.</p>	
<p>K. Committee Participation Insofar as possible, the institution should agree to provide for appropriate participation by the housestaff on the various committees within the institution. This participation should be on committees concerning institutional, professional and administrative matters including grievance and disciplinary proceedings. Members should have full voting rights. Representatives of the housestaff should be selected by the members of the housestaff.</p>	
<p>L. Grievance Procedures The contract or agreement should require and publish a grievance procedure. A grievance procedure typically involves the following: (1) A definition of the term "grievance" (e.g., any dispute or controversy about the interpretation or application of the contract, any rule or regulation, or any policy or practice). (2) The timing, sequence, and end point of the grievance procedure. (3) The right to legal or other representation. (4) The right of an individual member of the housestaff or a housestaff association to initiate a grievance procedure and the obligation of the housestaff to maintain patient care during the grievance procedure. (5) A statement of the bases and procedures for the final decision on grievances (end point), and agreement of both parties to abide by the decision. (6) Should costs arise in the grievance</p>	

procedure, a prior agreement as to how these costs will be apportioned between the parties.	
M. Disciplinary Hearings and Procedure With respect to disciplinary procedures, the provisions of Article VIII - Hearing and Appellate Review Procedure of the JCAHO Guidelines for the Formulation of Medical Staff Bylaws, Rules, and Regulations shall be applicable to the housestaff in the same manner as they are to all other members of the medical staff with the proviso that the Hearing and Appeals Committees shall contain appropriate representation of the housestaff.	
N. Description of the Educational Program The specific details of the operation of the educational experience should be made available to each prospective candidate. These data should include specific descriptions of training programs, including numbers of resident positions at each level of training, copies of existing housestaff contracts or agreements, approval status of programs to which candidate is applying, methods of evaluation, procedures for grievances and disciplinary action, and commitments for further training.	
O. Patient-Care Issues The quality of patient-care services and facilities may be specified in the contract, and could include such matters as adequate equipment, bedspace, clinical staffing, and clinical staff structuring.	
P. Other Provisions The agreement should provide for adequate, comfortable, safe, and sanitary facilities.	
The foregoing provisions are not all-inclusive. Depending upon the institution's size, resources, location, and affiliations, if any, and also depending upon the relationship between the institution and the housestaff association, other provisions may be included, such as: (1) Maintenance of existing benefits and practices not otherwise expressly covered; (2) Housing, meals, laundry, uniforms, living-out and telephone allowances; (3) Adequate office space, facilities, and supporting services for housestaff affairs; (4) Housestaff association seminars and meetings	
BOT Rep. H, I-74; Reaffirmed: CLRPD Rep. C, A-89; Appended: Res.323, I-97; Reaffirmation A-00; Reaffirmation A-08	

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 951
(I-18)

Introduced by: Resident and Fellow Section

Subject: Prevention of Physician and Medical Student Suicide

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

Whereas, The rate of suicide completion among medical professionals exceeds that of the combined U.S. population; and

Whereas, Suicides among physicians are perceived as isolated events¹; and

Whereas, Job stress is an independent risk factor for physician suicide²; and

Whereas, More understanding is needed about what systemic factors lead physicians to suicide; and

Whereas, Current AMA policy addresses a physician's or student's responsibility to seek mental health care, and encourages confidential reporting of risk factors by medical students, but does not include consequences for institutions that do not work to prevent suicide; and

Whereas, Work conditions beyond resident work hours, such as bullying, can contribute to suicide³; and

Whereas, Media coverage of physician suicide has increased dramatically in the past year; therefore be it

RESOLVED, That our American Medical Association request that the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education collect data on medical student, resident and fellow suicides to identify patterns that could predict such events.
(Directive to Take Action)

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

Received: 09/27/18

The topic of this resolution is currently under study by the Council on Medical Education.

References:

1 <https://www.fastcompany.com/3056015/thehiddenepidemicofdoctorsuicides>

2 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3549025/#idm140038005580816aff-infotitle>

3 <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0150246>

RELEVANT AMA POLICY**Access to Confidential Health Services for Medical Students and Physicians H-295.858**

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
 - A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
 - B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
 - C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
 - D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
 2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
 3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
 - A. be available to all medical students on an opt-out basis;
 - B. ensure anonymity, confidentiality, and protection from administrative action;
 - C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
 - D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
 4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
 5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
 6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
 7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
- Citation: CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 952
(I-18)

Introduced by: International Medical Graduates Section

Subject: IMG Section Member Representation on Committees/Task Forces/Councils

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

1 Whereas, The American Medical Association has a very good, long-standing relationship with
2 the Educational Commission for Foreign Medical Graduates (ECFMG); and
3

4 Whereas, The AMA has a dedicated section for international medical graduates, the AMA-IMG
5 Section; and
6

7 Whereas, The AMA has the ability to appoint regularly one representative to the ECFMG Board
8 of Trustees; and
9

10 Whereas, The ECFMG mission is to promote quality health care for the public by certifying
11 international medical graduates for entry into U.S. graduate medical education, and by
12 participating in the evaluation and certification of other physicians and health care professionals
13 nationally and internationally; and
14

15 Whereas, IMGs are the main reason of existence of the ECFMG and represent 26% of the
16 physician workforce in the U.S.; and
17

18 Whereas, IMGs are best suited to understand and decipher IMG issues; therefore be it
19

20 RESOLVED, That the American Medical Association ask the Educational Commission for
21 Foreign Medical Graduates (ECFMG) to increase the number of international medical graduates
22 (IMGs) proportionate to the percentage of IMGs serving in the U.S. on their councils,
23 committees, and/or task forces. (Directive to Take Action)

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

Received: 09/28/18

Reference:

<https://www.ecfm.org/about/leadership.html>

RELEVANT AMA POLICY

AMA Principles on International Medical Graduates H-255.988

Our AMA supports:

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.

3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

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

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

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

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

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

(BOT Rep. Z, A-86 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-13 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16 Appended: Res. 304, A-17 Modified: CME Rep. 01, I-17)

Visa Complications for IMGs in GME D-255.991

1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.

2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs' inability to complete accredited GME programs.

3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.

4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

(Res. 844, I-03 Reaffirmation A-09 Reaffirmation I-10 Appended: CME Rep. 10, A-11 Appended: Res. 323, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 953
(I-18)

Introduced by: Resident and Fellow Section

Subject: Support for the Income-Driven Repayment Plans

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

1 Whereas, Since 2009 the U.S. Department of Education created several Income-Driven
2 Repayment (IDR) plans that allow borrowers to select one of five plans for repaying their loans
3 with base payment amounts based on the borrower's income and repayment periods extended
4 from the standard ten years to up to twenty-five years with any remaining balance forgiven at the
5 end of that period (these new loans went into effect for all new loans as of July 1, 2014)¹; and
6

7 Whereas, The cost of these plans had not been adequately budgeted for by the Department of
8 Education, leading to proposed budget cuts to programs including IDR plans and the Public
9 Service Loan Forgiveness (PSLF) program¹⁻³; and
10

11 Whereas, Our AMA has made a concerted effort to reduce the burden of student loan debt, but
12 has not specifically address IDR plans and their relevance to current and future medical
13 students; therefore be it
14

15 RESOLVED, That our American Medical Association advocate for continued funding of
16 programs including Income-Driven Repayment plans for the benefit of reducing medical student
17 loan burden. (New HOD Policy)

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

Received: 09/27/18

References:

1 <https://www.gao.gov/products/GAO-17-22>

2 https://www.washingtonpost.com/news/grade-point/wp/2017/05/17/trump-and-devos-plan-to-reshape-higher-education-finance-heres-what-it-might-mean-for-you/?utm_term=.45d5f0a6d200

3 <https://www.cnn.com/2017/05/24/trumps-budget-seeks-to-cut-one-major-benefit-of-federal-student-loans.html>

RELEVANT AMA POLICY

H-305.965 Student Loans

Our AMA: (1) reaffirms its support of legislation that would defer the repayment of loans for education until the completion of residency training; and (2) will lobby for deferment of medical student loans for the full initial residency period. (Sub. Res. 203, A-90; Appended Res. 306, I-99; Reaffirmation A-01; Reaffirmation I-06; Modified: CME Rep 01, A-16)

Proposed Revisions to AMA Policy on Medical Student Debt D-305.970

Our AMA will:

1. Collaborate, based on AMA policy, with members of the Federation and the medical education community, and with other interested organizations, to achieve the following immediate public- and private-sector advocacy goals:

- (a) Support expansion of and adequate funding for federal scholarship and loan repayment programs, such as those from the National Health Service Corps, the Indian Health Service, the Armed Forces, and the Department of Veterans Affairs, and for comparable programs at the state level.
 - (b) Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
 - (c) With each reauthorization of the Higher Education Act and at every other legislative opportunity, proactively pursue loan consolidation terms that favor students and ensure that loan deferment is available for the entire duration of residency and fellowship training.
 - (d) Ensure that the Higher Education Act and other legislation allow interest from medical student loans to be fully tax deductible.
 - (e) Encourage medical schools, with the support of the Federation, to engage in fundraising activities devoted to increasing the availability of scholarship support.
 - (f) Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
 - (g) Support stable funding for medical education programs to limit excessive tuition increases.
2. Encourage medical schools to study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, combined baccalaureate/MD programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education. (CME Rep. 13, A-06; Reaffirmation I-08)

D-305.978 Mechanisms to Reduce Medical Student Debt

Our AMA will:

- (1) take an active advocacy role during the upcoming reauthorization of the Higher Education Act and other pending legislation, to achieve the following goals: (a) eliminating the single holder rule, (b) making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training, (c) retaining the option of loan forbearance for residents ineligible for loan deferment, (d) including, explicitly, dependent care expenses in the definition of the "cost of attendance," (e) including room and board expenses in the definition of tax-exempt scholarship income, (f) continuing the loan consolidation program, including the ability to "lock in" a fixed interest rate, and (g) adding the ability to refinance Federal Consolidation Loans;
- (2) continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases;
- (3) encourage members of the Federation to develop or enhance financial aid opportunities for medical students;
- (4) continue to monitor the availability of financial aid opportunities and financial planning/debt management counseling at medical schools, and share innovative approaches with the medical education community;
- (5) continue to collect and disseminate information to assist members of the Federation (state medical societies and specialty societies) and medical schools to establish or expand financial aid programs; and
- (6) continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students. (CME Rep. 10, A-04; Reaffirmation I-08)

D-305.980 Immediate Legislative Solutions to Medical Student Debt

Our AMA will: (1) endorse and actively lobby for the Reauthorization of the Higher Education Act, including: (a) Elimination of the "single-holder" rule; (b) Continuation of the consolidation loan program and a consolidator's ability to lock in a fixed interest rate; (c) Expansion of the deferment period for loan repayment to cover the entire duration of residency and fellowship; (d) Broadening of the definition of economic hardship as used to determine eligibility for student loan deferment; (e) Retention of the option of loan forbearance for residents who are ineligible for student loan deferment; and (f) Inclusion of dependent care expenses in the definition of "cost of attendance"; and

(2) lobby for passage of legislation that would: (a) Eliminate the cap on the student loan interest deduction; (b) Increase the income limits for taking the interest deduction; (c) Include room and board expenses in the definition of tax-exempt scholarship income; and (d) Make permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001. (Res. 850, I-03; Reaffirmation I-08)

D-305.984 Reduction in Student Loan Interest Rates

1. Our AMA will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.
3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.
4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.
5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training. (Res. 316, A-03; Reaffirmed: BOT Rep. 28, A-13; Appended: Res. 302, A-13; Modified and Appended: 301, A-16)

Medical School Financing, Tuition, and Student Debt D-305.993

1. The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of developing web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection, loan repayment programs, and a rotating loan program; and creating an AMA scholarship program funded through philanthropy. The AMA also should collect and disseminate information on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other purposes.
2. Our AMA will vigorously advocate for ongoing, adequate funding for federal and state programs that provide scholarship or loan repayment funds in return for service, including funding in return for practice in underserved areas, participation in the military, and participation in academic medicine or clinical research. Obtaining adequate support for the National Health Service Corps and similar programs, tied to the demand for participation in the programs, should be a focus for AMA advocacy efforts.
3. Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
4. Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students.
5. Our AMA supports a requirement that medical schools inform students of all government loan opportunities and requires disclosure of reasons that preferred lenders were chosen.
6. Our AMA will urge the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements to include a requirement that financial planning/debt management counseling be provided for resident physicians.
7. Our AMA will work with other organizations, including the Association of American Medical Colleges, residency program directors groups, and members of the Federation, to develop and disseminate standardized information, for example, computer-based modules, on financial planning/debt management for use by medical students, resident physicians, and young physicians.
8. Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of increasing loan deferment through the period of residency, promoting the expansion of subsidized loan programs, eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans.
9. Our AMA will advocate against putting a monetary cap on federal loan forgiveness programs.
10. Our AMA will: (a) advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; (b) work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be at least equal to the principal amount borrowed; and (c) ask the United States Department of Education to include all terms of Public Service Loan Forgiveness in the contractual obligations of the Master Promissory Note.
11. Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to require programs to include within the terms, conditions, and benefits of appointment to the program (which must be provided to applicants invited to interview, as per ACGME Institutional Requirements) information regarding the Public Service Loan Forgiveness (PSLF) program qualifying status of the employer.

12. Our AMA will advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility.

13. Our AMA encourages medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.

14. Our AMA encourages medical school financial advisors to promote to medical students service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.

15. Our AMA will strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

Citation: CME Rep. 2, I-00; Reaffirmation I-03; Reaffirmation I-06; Reaffirmation A-13; Appended: Res. 323, A-14; Appended: Res. 324, A-15; Appended: Res. 318, A-16; Appended: CME Rep. 07, A-17;

Modified: CME Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 954
(I-18)

Introduced by: American Academy of Dermatology, American Society for Dermatologic Surgery Association, American Society of Dermatopathology

Subject: VHA GME Funding

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

1 Whereas, The Veterans Health Administration (VHA) takes pride in providing the largest
2 education and training enterprise for graduate medical education (GME), training over 40,000
3 resident physicians annually¹; and
4

5 Whereas, Resident physicians provide care directly to veterans and expand VHA's clinical
6 capacity, allowing VHA patients to be seen more quickly¹; and
7

8 Whereas, VHA provides care in a team-based, patient centered, interprofessional work
9 environment with innovative technologies for care, which models the future of integrated health
10 care delivery¹; and
11

12 Whereas, VHA is working to expand graduate medical education in primary care, mental health,
13 and areas of physician shortages¹; and
14

15 Whereas, Increasing physician shortages nationwide are predicted in primary care and specialty
16 care, including in the VA system; and 60% of current VHA physicians received training with
17 VHA^{1,2}; and
18

19 Whereas, Our American Medical Association supports GME expansion³; and
20

21 Whereas, The ongoing funding of the VA Missions Act expanding private health care options will
22 cost billions and its funding may result in cuts to existing VHA programs⁴; therefore be it
23

24 RESOLVED, That our American Medical Association continue to support the mission of the
25 Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate
26 medical education (GME) residency positions (Directive to Take Action); and be it further
27

28 RESOLVED, That our AMA collaborate with appropriate stakeholder organizations to advocate
29 for preservation of Veterans Health Administration (VHA) funding for GME and support its
30 efforts to expand GME residency positions in the federal budget and appropriations process
31 (Directive to Take Action); and be it further
32

33 RESOLVED, That our AMA oppose service obligations linked to VHA GME residency or
34 fellowship positions, particularly for resident physicians rotating through the VA for only a portion
35 of their GME training. (New HOD Policy)

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

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¹ VA.gov

² https://aamc-black.global.ssl.fastly.net/production/media/filer_public/85/d7/85d7b689-f417-4ef0-97fb-ecc129836829/aamc_2018_workforce_projections_update_april_11_2018.pdf

³ The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

⁴ <https://www.stripes.com/news/mission-act-gets-funding-under-historically-high-va-budget-agreement-1.547070>

RELEVANT AMA POLICY

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap-setting deadline for new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates rates of placement into GME as well as GME completion.

33. Our AMA will investigate the status of implementation of AMA Policies D-305.973, Proposed Revisions to AMA Policy on the Financing of Medical Education Programs and D-305.967, The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education and report back to the House of Delegates with proposed measures to resolve the problems of underfunding, inadequate number of residencies and geographic maldistribution of residencies.

Sub. Res. 314, A-07 Reaffirmation I-07 Reaffirmed: CME Rep. 4, I-08 Reaffirmed: Sub. Res. 314, A-09 Reaffirmed: CME Rep. 3, I-09 Reaffirmation A-11 Appended: Res. 910, I-11 Reaffirmed in lieu of Res. 303, A-12 Reaffirmed in lieu of Res. 324, A-12 Reaffirmation: I-12 Reaffirmation A-13 Appended: Res. 320, A-13 Appended: CME Rep. 5, A-13 Appended: CME Rep. 7, A-14 Appended: Res. 304, A-14 Modified: CME Rep. 9, A-15 Appended: CME Rep. 1, I-15 Appended: Res. 902, I-15 Reaffirmed: CME Rep. 3, A-16 Appended: Res. 320, A-16 Appended: CME Rep. 04, A-16 Appended: CME Rep. 05, A-16 Reaffirmation A-16 Appended: Res. 323, A-17 Appended: CME Rep. 03, A-18 Appended: Res. 319, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 955
(I-18)

Introduced by: Medical Student Section

Subject: Equality for COMLEX and USMLE

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

1 Whereas, On February 26, 2014, the Accreditation Council for Graduate Medical Education
2 (ACGME), American Osteopathic Association (AOA), and American Association of Colleges of
3 Osteopathic Medicine (AACOM) announced their agreement to a Memorandum of
4 Understanding, outlining a single graduate medical education accreditation system in the United
5 States;¹ and

6
7 Whereas, “By December 31, 2017, AOA programs that are three years or longer in length were
8 required to apply to the ACGME in order to recruit residents in the 2018 AOA Match,” and the
9 AOA training programs are no longer able to accept residents if they cannot complete their
10 training by June 30, 2020;² and

11
12 Whereas, The listed benefits of the single accreditation system are to “ensure all residency and
13 fellowship applicants are eligible to enter all accredited programs in the United States, and can
14 transfer from one accredited program to another without repeating training, and without causing
15 the Sponsoring Institutions to lose Medicare funding;”³ and

16
17 Whereas, In 2017, 709 residency programs across the United States participated in the National
18 Match Service, the osteopathic version of NRMP, and as of January 2, 2018, 68% of those
19 programs have applied for the single GME accreditation system;^{2,4-5} and

20
21 Whereas, The ACGME views the COMLEX and USMLE as equivalent licensing board exams
22 and “does not specify which licensing board exam(s) (i.e., COMLEX-USA, USMLE) applicants
23 must take to be eligible for appointment in ACGME-accredited residency programs;”⁶ and

24
25 Whereas, According to the 2016 NRMP Program Director Survey, for all specialties, only 77% of
26 program directors use COMLEX Level 1 for pass only and with a target score in mind, but 99%
27 of program directors use USMLE Step 1 for pass only and with a target score in mind;⁷ and

28
29 Whereas, According to the 2016 NRMP Program Director Survey, for all specialties, only 65% of
30 Program Directors use COMLEX Level 2 PE, but 78% of Program Directors use USMLE Step 2
31 CS scores;⁷ and

32
33 Whereas, Original research yielded much lower COMLEX score acceptance with 51.6% of
34 NRMP residency programs in Ohio, 53.3% of NRMP residency programs in Colorado, and
35 39.4% of NRMP residency programs in Utah reporting acceptance of COMLEX Step 1 scores;⁸⁻
36 ⁹⁵ and

1 Whereas, As an examination constructed to assess the basic science knowledge of allopathic
2 medical students, the NBME-CBSE is effective at predicting performance on COMLEX-USA
3 Level 1 for osteopathic medical students, implying that the same basic science knowledge is
4 expected for DO and MD students;⁹⁶ and
5

6 Whereas, A recent study of 795 students from three osteopathic medical schools who took both
7 USMLE Step 1 and COMLEX Level 1 found that scores were statistically significant across all
8 three schools and that there was "a strong association between COMLEX Level 1 and USMLE
9 Step 1 performance";⁹⁷ and
10

11 Whereas, A formula exists to convert COMLEX Level 1 and USMLE Step 1 scores, however,
12 research has shown that attempts to derive a USMLE score from a COMLEX score using the
13 Slocum and Louder formula predicted lower scores by an average of 14.16 points (6.8%), and
14 cautioned residency program directors from using such conversion methods;⁹⁸ and
15

16 Whereas, Dr. Jon Gimpel, President of the NBOME, stated that "because of the different
17 natures of the examinations, it is not possible—or even desirable—to make a direct numerical
18 comparison between the scores of the COMLEX-USA examination series and those of the
19 USMLE. When it comes to the examinations, the NBOME encourages residency program
20 directors to consider the COMLEX-USA series as the valid and most appropriate assessment
21 tool for osteopathic medical students. Our goal is to increase program directors' understanding
22 of the COMLEX-USA examination series, including its content, development, validity, and
23 scoring";⁹⁹ and
24

25 Whereas, "The single GME accreditation system is not expected to reduce acceptance of the
26 COMLEX-USA for residency admissions, but rather to continue to grow acceptance with the
27 goal of one day achieving universal acceptance. However, it is likely – at least for a while – that
28 some ACGME programs will continue to prefer to receive a USMLE score";¹⁰⁰ and
29

30 Whereas, Equal acceptance of COMLEX and USMLE would still enable allopathic medical
31 students to enter residency programs with osteopathic recognition since "Any graduate of a
32 college of medicine accredited by the Commission on Osteopathic College Accreditation
33 (COCA), medical school within the United States or Canada accredited by the Liaison
34 Committee on Medical Education (LCME), or medical school outside of the United States or
35 Canada that meets the established eligibility criteria will be eligible to enter an ACGME-
36 accredited program, including any program with Osteopathic Recognition";³ therefore be it
37

38 RESOLVED, That our American Medical Association promote equal acceptance of the USMLE
39 and COMLEX at all United States residency programs (New HOD Policy); and be it further
40

41 RESOLVED, That our AMA work with appropriate stakeholders including but not limited to the
42 National Board of Medical Examiners, Association of American Medical Colleges, National
43 Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education
44 and American Osteopathic Association to educate Residency Program Directors on how to
45 interpret and use COMLEX scores (Directive to Take Action); and be it further
46

47 RESOLVED, That our AMA work with Residency Program Directors to promote higher
48 COMLEX utilization with residency program matches in light of the new single accreditation
49 system. (Directive to Take Action)

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

Received: 09/28/18

REFERENCES

1. Single GME Accreditation System. <http://www.acgme.org/What-We-Do/Accreditation/Single-GME-Accreditation-System>. Accessed March 20, 2018.
2. Single GME Accreditation System News and Updates. American Association of Colleges of Osteopathic Medicine. <http://www.aacom.org/news-and-events/single-gme/updates/2018/01/25/january-2018-single-gme-accreditation-system-update>. Accessed January 29, 2018.
3. Single GME FAQs. Accreditation Council for Graduate Medical Education. <http://www.acgme.org/Portals/0/PDFs/Nasca-Community/FAQs.pdf?ver=2017-06-22-110310-923>. Accessed December 22, 2017.
4. List of Participating Programs. National Match Service Inc. <https://www.natmatch.com/cgibin/instdisp.pl>. Accessed January 29, 2018.
5. Summary of Positions Offered and Filled by Program Type. National Match Service Inc. <https://natmatch.com/aoairp/stats/2017prgstats.html>. Accessed January 29, 2018.
6. Results of the 2016 NRMP Program Director Survey. National Resident Matching Program. <http://www.nrmp.org/wp-content/uploads/2016/09/NRMP-2016-Program-Director-Survey.pdf>. Accessed December 22, 2017.
7. Sandella JM, Gimpel JR, Smith LL, Boulet JR. The Use of COMLEX-USA and USMLE for Residency Applicant Selection. *Journal of Graduate Medical Education*. 2016;8(3):358-363. doi:10.4300/JGME-D-15-00246.1.
8. Search FREIDA Online. American Medical Association. <https://www.ama-assn.org/life-career/search-freida-online-ama-residency-fellowship-database>. Accessed December 24, 2017.
9. Graduate Medical Education Eligibility Requirements for the Match. Cleveland Clinic Akron General. http://www.akrongeneral.org/portal/page/portal/AGMC_PAGEGROUP/Residency_Programs/Eligibility%20Requirements. Accessed December 23, 2017.
10. How to Apply. Aultman Graduate Medical Education. <http://aultmangme.weebly.com/how-to-apply.html>. Accessed December 23, 2017.
11. Family Medicine Residency. TriHealth. <https://www.trihealth.com/research-and-education/education/graduate-medical-education/family-medicine-residency/how-to-apply/>. Accessed December 23, 2017.
12. Frequently Asked Questions. Canton Medical Education Foundation Internal Medicine Residency. <http://www.cmefonline.com/faqs.html>. Accessed December 23, 2017.
13. Graduate Medical Education. MetroHealth. <https://gme.metrohealth.org/about/how-to-apply>. Accessed December 23, 2017.
14. Osteopathic Training Programs. University Hospitals Richmond Medical Center. <http://www.uhhospitals.org/richmond/education/osteopathic-training-programs>. Accessed December 23, 2017.
15. How to Apply for Pediatric Residency. Akron Children's Hospital. https://www.akronchildrens.org/cms/pediatric_residency_program_application_process/index.html. Accessed December 23, 2017.
16. How to Apply. The Christ Hospital/University of Cincinnati Family Medicine Residency. <https://tchucfmr residency.com/how-to-apply-1/>. Accessed December 24, 2017.
17. Recruiting. The Christ Hospital Health Network. <https://www.thechristhospital.com/about-the-network/clinical-education/internal-medicine-residency/Foreign%20Medical%20Graduate%20Info>. Accessed December 24, 2017.
18. Contact/Apply. Cincinnati Children's Hospital Medical Center. <https://www.cincinnatichildrens.org/education/clinical/specialty/neurology/apply>. Accessed December 24, 2017.
19. Applying to Our Program. Cleveland Clinic. <https://my.clevelandclinic.org/departments/medicine/medical-professionals/internal-medicine-residency-program/apply>. Accessed December 24, 2017.
20. Neurology Residencies. Cleveland Clinic. <https://my.clevelandclinic.org/departments/neurological/medical-professionals/residencies/neurology#adult-residency-program-tab>. Accessed December 24, 2017.
21. Physical Medicine & Rehabilitation Residency. Cleveland Clinic. <https://my.clevelandclinic.org/departments/neurological/medical-professionals/residencies/physical-medicine-rehabilitation#how-to-apply-tab>. Accessed December 24, 2017.
22. Adult Psychiatry Residency. Cleveland Clinic. <https://my.clevelandclinic.org/departments/neurological/medical-professionals/residencies/adult-psychiatry#how-to-apply-tab>. Accessed December 24, 2017.
23. Residency Program. Cleveland Clinic. <https://my.clevelandclinic.org/departments/pathology/medical-professionals/residency-program#application-tab>. Accessed December 24, 2017.
24. How to Apply. Cleveland Clinic. <https://my.clevelandclinic.org/pediatrics/medical-professionals/pediatric-residency/how-to-apply>. Accessed December 24, 2017.
25. Application Requirements. Fairview Hospital. <https://my.clevelandclinic.org/locations/fairview-hospital/about/residency/family-med-program/application>. Accessed December 24, 2017.
26. Online Application for Residency or Fellowship Program. Firelands Regional Medical Center. <https://www.firelands.com/education-training/medical-education/programs/online-application-for-residency-or-fellowship/>. Accessed December 24, 2017.
27. Graduate Medical Education. TriHealth. <https://www.trihealth.com/research-and-education/education/graduate-medical-education/>. Accessed December 24, 2017.
28. How to Apply to Grant Medical Center. OhioHealth. <https://www.ohiohealth.com/medical-education/how-to-apply/how-to-apply-to-grant-medical-center/>. Accessed December 24, 2017.
29. Graduate Medical Education. MercyHealth. <https://www.mercy.com/cincinnati/about-us/careers-and-job-openings/residency-programs/graduate-medical-education>. Accessed December 24, 2017.
30. Family Medicine Residency at Soin Medical Center. Kettering Health Network. <https://www.ketteringhealth.org/soinmeded/>. Accessed December 24, 2017.
31. Internal Medicine Residency Program. Kettering Health Network. <https://ketteringhealth.org/ketteringmeded/imresidency/>. Accessed December 24, 2017.
32. Residency Program Information. Memorial Health System. <http://www.mhsystem.org/emrinfo>. Accessed December 24, 2017.
33. Programs. Mount Carmel Medical Education. <https://gme.mchs.com/programs>. Accessed December 24, 2017.
34. Residency Programs. Nationwide Children's Hospital. <http://www.nationwidechildrens.org/residency-programs>. Accessed December 24, 2017.
35. Residents and Fellows. The Ohio State University College of Medicine. <https://medicine.osu.edu/residents/residencies/pages/index.aspx>. Accessed December 25, 2017.
36. How to Apply to Riverside Methodist. OhioHealth. <https://www.ohiohealth.com/medical-education/how-to-apply/how-to-apply-to-riverside-methodist/>. Accessed December 25, 2017.
37. St. Elizabeth Boardman Family Medicine Residency Program Eligibility Criteria. MercyHealth. <https://www.mercy.com/youngstown/locations/hospitals/mercy-health-st-elizabeth-boardman-hospital/medical-education-and-residency-programs/family-medicine-residency/eligibility-criteria>. Accessed December 25, 2017.
38. Medical Education & Residency Programs. MercyHealth. <https://www.mercy.com/youngstown/locations/hospitals/mercy-health-st-elizabeth-youngstown-hospital/medical-education-and-residency-programs>. Accessed December 25, 2017.
39. Application Overview. St. Vincent Charity Medical Center. http://www.stvincentresidency.org/application_overview.html. Accessed December 25, 2017.
40. St. Vincent Medical Center Residency Programs. MercyHealth. <http://mercymedicalresidency.org/wp/>. Accessed December 25, 2017.
41. Medical Education. Summa Health. <https://www.summahealth.org/medicaleducation>. Accessed December 25, 2017.
42. Residency Programs. University of Cincinnati College of Medicine. <https://med.uc.edu/gme/residencyprograms>. Accessed December 26, 2017.
43. Graduate Medical Education. University of Toledo. <http://www.utoledo.edu/med/gme/>. Accessed December 26, 2017.
44. Graduate Medical Education at Western Reserve Hospital. Western Reserve Hospital. <https://www.westernreservehospital.org/education.aspx>. Accessed December 26, 2017.
45. Residency and Fellowship Programs. Wright State University. <https://medicine.wright.edu/education/residency-and-fellowship-programs>. Accessed December 26, 2017.
46. DHREM Applicant FAQ. <http://www.denverem.org/applicant-faq>. Accessed March 14, 2018.
47. Poudre Valley Hospital/Fort Collins Family Medicine Residency Program. <https://www.uchealth.org/professionals/residencies/family-medicine-residency-program/>. Accessed March 14, 2018.
48. Sky Ridge Medical Center Family Medicine Residency. http://opportunities.osteopathic.org/search/search_details.cfm?program_id=372202&returnPage=3&CFID=1149220&CFTOKEN=c5102aae898a9bc4-BB29C8DA-A85D-BFAD-9674F393BFCBBD22&sessionid=f030e09cfc154d69a80f5e3b77c7e777a502. Accessed March 14, 2018.
49. Banner Health Application Criteria. <https://www.bannerhealth.com/health-professionals/residency-fellowships/north-colorado-family-medicine/residency-applicants>. Accessed March 14, 2018.
50. St. Anthony North Family Medicine Residency Application. <https://www.centura.org/Education-and-Training/Residencies-and-Internships/St-Anthony-Family-Medicine-Residency/About-Us>. Accessed March 14, 2018.
51. SCL Health St. Joseph Hospital Applications. <https://www.sclhealth.org/locations/saint-joseph-hospital/for-medical-professionals/graduate-medical-education/about-our-programs/applications/>. Accessed March 14, 2018.
52. SCL Health St. Joseph Hospital Applications. <https://www.sclhealth.org/locations/saint-joseph-hospital/for-medical-professionals/graduate-medical-education/internal-medicine-residency/applicants/>. Accessed March 14, 2018.
53. SCL Health St. Joseph Hospital Applications. <https://www.sclhealth.org/locations/saint-joseph-hospital/for-medical-professionals/graduate-medical-education/general-surgery/applications/>. Accessed March 14, 2018.
54. SCL Health St. Joseph Hospital Applications. <https://www.sclhealth.org/locations/saint-joseph-hospital/for-medical-professionals/graduate-medical-education/ob-gyn/applications/>. Accessed March 14, 2018.
55. Southern Colorado Family Medicine Resident Application Information. <https://www.centura.org/education-and-training/residencies-and-internships/southern-colorado-family-medicine-residency/student-information>. Accessed March 14, 2018.

56. SCL Health St. Mary's Family Medicine Residency Program Applications and Interview. <https://www.sclhealth.org/locations/st-marys-medical-center/for-healthcare-professionals/family-medicine-residency-program/application-and-interview/>. Accessed March 14, 2018.
57. CU School of Medicine Department of Anesthesiology Residency Training. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/Anesthesiology/Education/residency/Pages/application.aspx>. Accessed March 14, 2018.
58. CU School of Medicine Department of Dermatology Residency Training. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/Dermatology/training/Pages/Residency.aspx>. Accessed March 14, 2018.
59. CU School of Medicine Department of Family Medicine Residency Training. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/familymed/education/residencies/UHresidency/aboutprogram/application/Pages/default.aspx>. Accessed March 14, 2018.
60. Rose Family Medical Center Eligibility Requirements. <http://rfmr.wpengine.com/resident-applicants/eligibility/>. Accessed March 14, 2018.
61. Swedish Family Medicine Residency. <http://sfmr.wpengine.com/application/>. Accessed March 14, 2018.
62. CU School of Medicine Department of Internal Medicine Primary Care. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/medicine/intmed/howtoapply/Pages/default.aspx>. Accessed March 14, 2018.
63. CU School of Medicine Department of Neurology Application Process. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/neurology/residency/howtoapply/Pages/howtoapply.aspx>. Accessed March 14, 2018.
64. CU School of Medicine Department of Pediatrics. Child Neurology Residency Program. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/pediatrics/subs/genetics/educat/fellows/Pages/Child-Neurology-Residency-Program.aspx>. Accessed March 14, 2018.
65. CU School of Medicine Department of Neurosurgery Residency Program. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/Neurosurgery/education/ResidencyProgram/Pages/residencyprogram.aspx>. Accessed March 14, 2018.
66. CU School of Medicine Department of Obstetrics and Gynecology Residency Recruitment and Selection. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/obgyn/Education/ResidentProgram/FortheApplicant/Pages/Applicantinfo.aspx>. Accessed March 14, 2018.
67. CU School of Medicine Department of Orthopedics Prospective Residents. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/Orthopaedics/education/residency/Pages/Prospective-Residents.aspx>. Accessed March 14, 2018.
68. CU School of Medicine Department of Pathology Residency Application Process. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/Pathology/academicprograms/Pages/residencyapplicationinformation.aspx>. Accessed March 14, 2018.
69. CU School of Medicine Department of Pediatrics Residency Program. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/pediatrics/meded/residency/Pages/HowToApply.aspx>. Accessed March 14, 2018.
70. CU School of Medicine Department of Physical Medicine and Rehabilitation Residency Training Application Information. http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/pmr/Education/ResidencyTraining/Pages/Application_Information.aspx. Accessed March 14, 2018.
71. CU School of Medicine Department of Psychiatry Residency Program. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/psychiatry/PsychEducation/PsychResidency/Pages/PsychiatryResidencyEligibilityApplication.aspx>. Accessed March 15, 2018.
72. CU School of Medicine Department of Radiology Residency How To Apply. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/Radiology/Education/residency/Pages/How-to-Apply.aspx>. Accessed March 15, 2018.
73. CU School of Medicine Department of Surgery. General Surgery Application Process. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/surgery/education/GeneralSurgeryResidency/Pages/ApplicationProcess.aspx>. Accessed March 15, 2018.
74. CU School of Medicine Medicine-Pediatric Residency Training Program Application Process. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/medicine/MedPeds/Pages/Non%20Article/How-to-apply.aspx>. Accessed March 15, 2018.
75. CU School of Medicine Department of Pediatrics Clinical Genetics and Metabolism Residency Program. <http://www.ucdenver.edu/academics/colleges/medicalschoold/departments/pediatrics/subs/genetics/educat/fellows/Pages/fellows.aspx>. Accessed March 15, 2018.
76. Colorado School of Public Health Occupational and Environmental Residency Admissions. <http://www.ucdenver.edu/academics/colleges/PublicHealth/Academics/GME/Programs/OME/Pages/Admissions.aspx>. Accessed March 15, 2018.
77. Colorado School of Public Health Preventative Medicine Residency Admissions. <http://www.ucdenver.edu/academics/colleges/PublicHealth/Academics/GME/Programs/PMR/Pages/Admissions.aspx>. Accessed March 15, 2018.
78. Intermountain Health Care Transitional Year Residency How to Apply. <https://intermountainhealthcare.org/careers/residencies-training/medical-resident-fellow-training/transitional-year-residency/application-information/how-to-apply/>. Accessed March 15, 2018.
79. Intermountain Health Care Family Medicine Residency How to Apply. <https://intermountainhealthcare.org/careers/residencies-training/medical-resident-fellow-training/mckay-dee-family-medicine-residency/application-information/how-to-apply/>. Accessed March 15, 2018.
80. University of Utah School of Medicine Anesthesiology Residency How to Apply. <http://medicine.utah.edu/anesthesiology/education/residency/how-to-apply.php>. Accessed March 15, 2018.
81. University of Utah School of Medicine Dermatology Residency How to Apply. <http://medicine.utah.edu/dermatology/education/residency/apply/>. Accessed March 15, 2018.
82. University of Utah School of Medicine Emergency Medicine Residency Application Requirements. http://medicine.utah.edu/surgery/emergency_medicine/residency/application-requirements.php. Accessed March 15, 2018.
83. University of Utah School of Medicine Family Medicine Residency Application. <http://medicine.utah.edu/dfpm/family-medicine/residency/application.php>. Accessed March 15, 2018.
84. University of Utah School of Medicine Internal Medicine Residency How to Apply. <http://medicine.utah.edu/internalmedicine/residency/applicants/apply.php>. Accessed March 15, 2018.
85. University of Utah School of Medicine Internal Medicine Residency International Partnership. <http://medicine.utah.edu/internalmedicine/residency/applicants/intl.php>. Accessed March 15, 2018.
86. University of Utah School of Medicine Adult Neurology Residency. <http://medicine.utah.edu/neurology/residencies/adult/application.php>. Accessed March 16, 2018.
87. University of Utah School of Medicine Obstetrics and Gynecology Residency Application. <http://medicine.utah.edu/obgyn/general-obstetrics-gynecology/residency/application.php>. Accessed March 16, 2018.
88. University of Utah School of Medicine Pathology Residency Application. <http://medicine.utah.edu/pathology/residency/application.php>. Accessed March 16, 2018.
89. University of Utah School of Medicine Pediatric Residency Application. http://medicine.utah.edu/pediatrics/pedsresidency/residency_program/categorical-program/application.php. Accessed March 16, 2018.
90. University of Utah School of Medicine PM&R Residency How to Apply. <http://medicine.utah.edu/pmr/residency/apply/>. Accessed March 16, 2018.
91. University of Utah School of Medicine Adult Psychiatry Residency Application. <http://medicine.utah.edu/psychiatry/adult/residency/application.php>. Accessed March 16, 2018.
92. University of Utah School of Medicine Child Psychiatry Residency Application. <http://medicine.utah.edu/psychiatry/child/residency/application.php>. Accessed March 16, 2018.
93. University of Utah School of Medicine Radiation Oncology Residency Eligibility and Application. <http://medicine.utah.edu/radiation-oncology/residency/application.php>. Accessed March 16, 2018.
94. University of Utah School of Medicine General Surgery Residency Application Checklist. http://medicine.utah.edu/surgery/general_surgery/residency/application.php. Accessed March 16, 2018.
95. Utah Valley Family Medicine Residency How to Apply. <https://intermountainhealthcare.org/careers/residencies-training/medical-resident-fellow-training/utah-valley-family-medicine/residency-program/application-information/how-to-apply/>. Accessed March 16, 2018.
96. Davis GE, Gayer GG. Comparison of basic science knowledge between DO and MD students. The Journal of the American Osteopathic Association, February 2017, Vol. 117, 114-123. doi:10.7556/jaoa.2017.022.
97. Licensing Board Exams. Accreditation Council for Graduate Medical Education. Students. <http://www.acgme.org/What-We-Do/Accreditation/Single-GME-Accreditation-System/AOA-Residents-and-Medical-Students>. Accessed December 22, 2017.
98. Albert S. Lee, Lynn Chang, Eric Feng, and Scott Helf (2014) Reliability and Validity of Conversion Formulas Between Comprehensive Osteopathic Medical Licensing Examination of the United States Level 1 and United States Medical Licensing Examination Step 1. Journal of Graduate Medical Education: June 2014, Vol. 6, No. 2, pp. 280-283.
99. Parikh, SP, Shiembob, CA. New COMLEX-USA-to-USMLE Conversion Formula Needed. The Journal of the American Osteopathic Association, July 2010, Vol. 110, 400-401.
100. Single GME Accreditation System FAQs. American Association of Colleges of Osteopathic Medicine. <https://www.aacom.org/news-and-events/single-gme/frequently-asked-questions/student-faqs>. Accessed April 7, 2018.

RELEVANT AMA POLICY

ACGME Residency Program Entry Requirements H-310.909

Our AMA supports entry into Accreditation Council on Graduate Medical Education (ACGME) accredited residency and fellowship programs from either ACGME-accredited programs or American Osteopathic Association-accredited programs. Res 920, I-12

Potential Impact of the USMLE Step 2 CS and COMLEX-PE on Undergraduate and Graduate Medical Education D-275.981

Our AMA will: (1) continue to closely monitor the USMLE Step 2 CS and the COMLEX-USA Level 2-PE, collecting data on initial and final pass rates, delays in students starting residency training due to scheduling of examinations, economic impact on students, and the potential impact of ethnicity on passing rates; and (2) encourage residency program directors to proactively evaluate their access to resources needed to assist resident physicians who have not passed these examinations to remediate. CME Rep. 4, A-04; Modified: CME Rep. 2, A-14

Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934

Our AMA adopts the following principles: (1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems, as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants. CME Rep. 8, A-99; Reaffirmed: CME Rep. 4, I-01; Reaffirmed: CME Rep. 2, A-11; Modified: CME Rep. 2, A-12

Independent Regulation of Physician Licensing Exams D-295.939

Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system; (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX).

Citation: CME Rep. 10, A-08; Modified: CME Rep. 01, A-18

Clinical Skills Assessment During Medical School D-295.988

1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.
2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.
4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.
5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.
6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.
7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary. CME Rep. 7, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: Alt. Res. 311, A-16; Appended: CME Rep. 09, A-17

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

Citation: Res. 307, A-09; Appended: Res. 955, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 956
(I-18)

Introduced by: Nebraska

Subject: Increasing Rural Rotations During Residency

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

Whereas, Residents of rural areas are generally older and sicker than their urban counterparts;
and

Whereas, Rural areas are facing a crisis due to physician shortages; and

Whereas, Residents and fellows are more likely to practice where they train; and

Whereas, Many residency programs offer elective rotations where residents can pursue areas
of interest not offered in their main residency curriculum; and

Whereas, The documentation requirements for faculty supervising residents can be substantial;
therefore be it

RESOLVED, That our American Medical Association work with state and specialty societies,
medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education
(ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested
stakeholders to encourage and incentivize qualified rural physicians to serve as preceptors,
volunteer faculty, etc. for rural rotations in residency (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the ACGME, the American Board of Medical Specialties,
the Federation of State Medical Boards, CMS and other interested stakeholders to lessen or
remove regulations or requirements on residency training and physician practice that preclude
formal educational experiences and rotations for residents in rural areas (Directive to Take
Action); and be it further

RESOLVED, That our AMA work with interested stakeholders to identify strategies to increase
residency training opportunities in rural areas with a report back to the House of Delegates
(Directive to Take Action); and be it further

RESOLVED, That our AMA work with state and specialty societies and other interested
stakeholders to identify appropriately qualified rural physicians who would be willing to serve as
preceptors for rural rotations in residency (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the ACGME and other interested stakeholders to lessen
the documentation requirements for off-site rural rotations during residency so that affiliated
rural supervising faculty can focus on educating rotating residents (Directive to Take Action);
and be it further

1 RESOLVED, That our AMA work with interested stakeholders to study other ways to increase
2 training in rural areas (Directive to Take Action); and be it further
3

4 RESOLVED, That our AMA formulate an actionable plan of advocacy based on the results of
5 the above study with the goal of increasing residency training in rural areas. (Directive to Take
6 Action)

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

Received: 09/28/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 957
(I-18)

Introduced by: Florida

Subject: Board Certifying Bodies

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

Whereas, The United States Department of Justice, Antitrust Division, set forth its views on Maryland House Bill 857 in a letter dated September 10, 2018 addressed to Dan K. Morhaim, M.D., a member of the Maryland House of Delegates; and

Whereas, The Division's letter focused on two questions – first, whether ABMS may harm competition by imposing overly burdensome conditions on physicians who wish to maintain their ABMS certification; and second, what are the policy options available to the Maryland legislature if the legislature concludes that the ABMS Program for Maintenance of Certification (MOC) program harms healthcare competition in Maryland; and

Whereas, The Division's letter recognized that “more entry and more competition by bona fide certifying bodies may offer important benefits – including lowering the costs for physicians to be certified or improving the quality of certification services – for healthcare providers, consumers, and payers”; and

Whereas, The Division's letter encouraged the Maryland legislature to consider ways to facilitate competition by legitimate certifying bodies, consistent with patient health and safety, and, towards that end, encouraged drafters of Maryland House Bill 857 to consider ways to allow for entry by additional, legitimate certifying bodies; and

Whereas, Multiple states are pursuing legislation to address issues arising from a lack of competition among bona fide certifying bodies; therefore be it

RESOLVED, That our American Medical Association conduct a study of the certifying bodies that compete with the American Board of Medical Specialties and issue a report opining on the qualifications of each such certifying body and whether each such certifying body should be added to the list of approved certifying entities in states where they are not currently approved (Directive to Take Action); and be it further

RESOLVED, That our AMA develop model state legislation that would encourage competition among qualified certifying bodies and would modify board certification requirements such that maintenance of certification participation would not be a requirement for board recertification. (Directive to Take Action)

Fiscal Note: Estimated cost to implement the resolution is \$30,000.

Received: 09/27/18

RELEVANT AMA POLICY

Maintenance of Certification H-275.924

AMA Principles on Maintenance of Certification (MOC)

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (*AMA PRA Category 1 Credit*®, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
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 present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
 22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
 23. Physicians with lifetime board certification should not be required to seek recertification.
 24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
 25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
 26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in MOC.
 27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.
- Citation: CME Rep. 16, A-09; Reaffirmed: CME Rep. 11, A-12; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 919, I-13; Appended: Sub. Res. 920, I-14; Reaffirmed: CME Rep. 2, A-15; Appended: Res. 314, A-15; Modified: CME Rep. 2, I-15; Reaffirmation A-16; Reaffirmed: Res. 309, A-16; Modified: Res. 307, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 319, A-17; Reaffirmed in lieu of: Res. 322, A-17; Modified: Res. 953, I-17

An Update on Maintenance of Licensure D-275.957

Our American Medical Association will: 1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.

2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues.
3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce.
4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL.
5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may help shape and support MOL for physicians.
6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.
7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.
8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time.

Citation: (CME Rep. 3, A-15; Modified: CME Rep. 2, I-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 958
(I-18)

Introduced by: California

Subject: National Health Service Corps Eligibility

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

Whereas, The National Health Service Corps (NHSC) provides scholarships and loan repayment for primary care physicians serving in health professional shortage areas (HPSAs); and

Whereas, The NHSC's purpose is to strengthen and grow the primary care workforce to improve access to care in medically underserved areas; and

Whereas, There are severe physician shortages in rural areas across the country; and

Whereas, Many primary care physicians provide care as inpatient hospitalists; and

Whereas, NHSC approved sites provide outpatient, ambulatory primary health care services in health professional shortage areas; and

Whereas, Many primary care physicians seeking to participate in the NHSC would like to participate as hospitalists; therefore be it

RESOLVED, That our American Medical Association consider eligibility criteria changes for the National Health Service Corps Program to increase the pool of eligible physicians, such as allowing participation from primary care physicians providing in-patient hospitalist care in health professional shortage areas. (Directive to Take Action)

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

Received: 10/11/18

RELEVANT AMA POLICY

Long-Term Solutions to Medical Student Debt D-305.975

Our AMA will: (1) encourage medical schools and state medical societies to consider the creation of self-managed, low-interest loan programs for medical students, and collect and disseminate information on such programs; (2) advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas; (3) work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment; (4) collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided; and (5) encourage the National Health Services Corps to have repayment policies that are

consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.

Citation: (CME Rep. 3, I-04; Reaffirmation I-06; Appended: Res. 321, A-12; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation I-14)

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988

In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that: (1) Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.

(2) Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.

(3) Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.

(4) Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.

(5) Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.

(6) Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

(7) Our AMA support full funding of the new federal National Health Service Corps loan repayment program.

(8) Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.

(9) Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.

(10) Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.

(11) Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.

(12) Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

Citation: CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08; Reaffirmed: CEJA Rep. 06, A-18

Effectiveness of Strategies to Promote Physician Practice in Underserved Areas D-200.980

1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following: (a) Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations. (b) Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program. (c) Adequate funding (up to at least FY 2005 levels) for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas.

2. Our AMA encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations.

3. Our AMA will advocate to states in support of the introduction or expansion of tax credits and other practice-related financial incentive programs aimed at encouraging physician practice in underserved areas.

4. Our AMA will advocate for the creation of a national repository of innovations and experiments, both successful and unsuccessful, in improving access to and distribution of physician services to government-insured patients (National Access Toolbox).

5. Our AMA supports elimination of the tax liability when employers provide the funds to repay student loans for physicians who agree to work in an underserved area.

Citation: CME Rep. 1, I-08; Modified: CME Rep. 4, A-10; Reaffirmation I-11; Appended: Res. 110, A-12; Reaffirmation A-13; Reaffirmation A-14; Appended: Res. 312, I-16; Appended: Res 312, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 959
(I-18)

Introduced by: Indiana

Subject: Physician and Medical Student Mental Health and Suicide

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

1 Whereas, The suicide rate of physicians and medical students is more than double that of the
2 general population, making it the profession with the highest suicide rate of any profession in
3 the United States; and
4

5 Whereas, One million U.S. patients lose one of their physicians each year due to physician
6 suicide; and
7

8 Whereas, Physicians and medical students are reluctant to report mental health issues and
9 suicidal thoughts because of fear of losing their medical privileges and/or medical license; and
10

11 Whereas, Physicians and medical students report rising stress and falling satisfaction from
12 their career choice; and
13

14 Whereas, Suicidal deaths and mental health issues are increasing with about 400 deaths in
15 2018 and in previous years; and
16

17 Whereas, Productivity and quality of patient care are negatively affected by physician and
18 medical student mental health issues; and
19

20 Whereas, Physicians and medical students are less likely to seek help and more likely to self-
21 medicate for mood disturbances; and
22

23 Whereas, Physician and medical student knowledge of physiology and pharmacology coupled
24 with access to lethal drugs, devices and techniques increases the risk of successful suicide;
25 and
26

27 Whereas, Physician and medical student death by suicide is a tragedy for family, friends,
28 patients and the community; and
29

30 Whereas, Physician and medical student death by suicide exacerbates growing physician
31 shortages; and
32

33 Whereas, AMA policy on physician and medical student mental health and suicide are
34 extensive and are reviewed by the Council on Science and Public Health (CSAPH); and
35

36 Whereas, Current AMA policy is inadequate because the suicide rate among physicians and
37 medical students is increasing; therefore be it

1 RESOLVED, That our American Medical Association create a new Physician and Medical
2 Student Suicide Prevention Committee with the goal of addressing suicides and mental health
3 disease in physicians and medical students. This committee will be charged with:
4

5 1) Developing novel policies to decrease physician and medical trainee stress and
6 improve professional satisfaction.
7

8 2) Vociferous, repeated and widespread messaging to physicians and medical
9 students encouraging those with mood disorders to seek help.
10

11 3) Working with state medical licensing boards and hospitals to help remove any
12 stigma of mental health disease and to alleviate physician and medical student
13 fears about the consequences of mental illness and their medical license and
14 hospital privileges.
15

16 4) Establishing a 24-hour mental health hotline staffed by mental health
17 professionals whereby a troubled physician or medical student can seek
18 anonymous advice. Communication via the 24-hour help line should remain
19 anonymous. This service can be directly provided by the AMA or could be
20 arranged through a third party, although volunteer physician counselors may be an
21 option for this 24-hour phone service. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 10/09/18

The topic of this resolution is currently under study by the Council on Medical Education.

RELEVANT AMA POLICY

Study of Medical Student, Resident, and Physician Suicide D-345.984

Our AMA will determine the most efficient and accurate mechanism to study the actual incidence of medical student, resident, and physician suicide, and report back at the 2018 Interim Meeting of the House of Delegates with recommendations for action.

Citation: Res. 019, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 960
(I-18)

Introduced by: Indiana

Subject: Inadequate Residency Slots

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

1 Whereas, The annual residency match this year resulted in 8,063 medical school graduates
2 (37,103 applicants with 29,040 matched and about 1000 more matches through the SOAP
3 [Supplemental Offer and Acceptance Program]) failing to find a residency program. This group
4 included U.S. medical school graduates, as well as international medical school graduates; and
5

6 Whereas, The AMA and ISMA both have policies on postgraduate medical education position
7 adequacy; and
8

9 Whereas, It is estimated that it costs up to \$0.5 million or more to produce one medical school
10 graduate in the United States. Students make a great investment of money, time and effort in
11 their training. For a medical school graduate to fail to become a duly licensed medical
12 practitioner is truly a tragedy, as well as a significant loss to the community. It is also a great
13 waste of public and private funds when the situation arises; and
14

15 Whereas, These graduates typically have debt that is equivalent to a home mortgage with
16 interest rates that are significant. Commonly, loan payments are set to begin shortly after
17 medical school graduation if the individual is not in a postgraduate program; and
18

19 Whereas, Some of these individuals are never able to complete their residencies and are
20 burdened with significant debt, and yet are not able to practice as a physician except in states
21 that have assistant physician programs. These programs typically are in medically underserved
22 communities offering a collaborating physician relationship; therefore be it
23

24 RESOLVED, That our American Medical Association adopt policy to establish parity between the
25 number of medical school graduates and the number of match positions and withhold support
26 for any further increase in medical school enrollment, unless there is a corresponding increase
27 in residency positions(New HOD Policy); and be it further
28

29 RESOLVED, That our AMA lobby the federal government for increased funding for residency
30 spots, to investigate other sustainable models for residency position funding and to advocate for
31 loan repayment waivers for individuals who fail to match. (Directive to Take Action)

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

Received: 10/09/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 961
(I-18)

Introduced by: Michigan

Subject: Protect Physician-Led Medical Education

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

1 Whereas, High quality education of our next generation of physicians is the most important
2 legacy we can provide our patients and profession; and
3

4 Whereas, Education, supervision, and evaluation of training physicians by physicians has been
5 a defining characteristic of our medical profession for thousands of years; and
6

7 Whereas, The rules for education, supervision, and evaluation of training physicians are
8 determined by the Liaison Committee on Medical Education (LCME) and Accreditation Council
9 for Graduate Medical Education (ACGME); and
10

11 Whereas, The member organizations of the LCME and ACGME include physician
12 organizations, as well as hospital organizations and hospital systems; and
13

14 Whereas, The economics and politics of health care have produced an unprecedented
15 proliferation of non-physicians providing highly specialized care in hospital systems without
16 graduating from LCME-approved medical school or ACGME-approved residency or fellowship
17 training; and
18

19 Whereas, The economics and politics of health care have produced an unprecedented
20 proliferation of hospital system employed physicians who may not be in a position to stand up
21 for themselves or their trainees; and
22

23 Whereas, Medical students, residents, and fellows are increasingly finding themselves trained,
24 supervised, and evaluated by non-physicians, in addition to losing valuable procedural
25 experience to non-physicians, with little understanding of their rights or how to report such
26 violations; and
27

28 Whereas, Non-physician members of the health care team can provide valuable education to
29 medical students, residents, and fellows within their scope of non-physician care as part of a
30 physician-led health care team, but this should not replace physician-led training, supervision
31 and evaluation of physician trainees; therefore be it
32

33 RESOLVED, That our American Medical Association, in their role as a member organization of
34 the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical
35 Education, strongly advocate for the rights of medical students, residents, and fellows to be
36 trained, supervised, and evaluated by licensed physicians (Directive to Take Action); and be it
37 further

- 1 RESOLVED, That our AMA provide medical students, residents, and fellows a clear online
- 2 resource outlining their rights, as per Liaison Committee on Medical Education and
- 3 Accreditation Council for Graduate Medical Education guidelines, to physician-led education
- 4 and a means to report violations without fear of retaliation. (Directive to Take Action)

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

Received: 10/10/18

RELEVANT AMA POLICY

Communication and Clinical Teaching Curricula D-295.329

Our AMA will:

1. encourage the Liaison Committee on Medical Education to continue to enforce accreditation standards requiring that faculty members and resident physicians are prepared for and evaluated on their teaching effectiveness;
2. encourage the Accreditation Council for Graduate Medical Education to create institutional-level standards related to assuring the quality of faculty teaching;
3. encourage medical schools and institutions sponsoring graduate medical education programs to offer faculty development for faculty and resident physicians in time-efficient modalities, such as online programs, and/or to support faculty and resident participation in off-site programs;
4. encourage medical educators to develop and utilize valid and reliable measures for teaching effectiveness; and
5. encourage medical schools to recognize participation in faculty development for purposes of faculty retention and promotion.

Citation: (CME Rep. 9, A-09)

Recommendations for Future Directions for Medical Education H-295.995

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

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

of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.

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

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

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

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

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

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

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

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

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

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

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

(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical

education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Citation: CME Rep. B, A-82; Amended: CLRPD Rep. A, I-92; Res. 331, I-95; Reaffirmed by Res. 322, A-97; Reaffirmation I-03; Modified: CME Rep. 7, A-05; Modified: CME Rep. 2, I-05; Appended: CME Rep. 5, A-11; Reaffirmed: CME Rep. 3, A-11; Modified: CME Rep. 01, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 962
(I-18)

Introduced by: Michigan

Subject: Improve Physician Health Programs

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

1 Whereas, In 2007, thirteen state Medical Boards indicated that the diagnosis of mental illness in
2 and of itself was sufficient for sanctioning physicians; and
3

4 Whereas, A Physician Health Program (PHP) is defined as a “confidential resource for
5 physicians, other licensed healthcare professionals, or those in training suffering from addictive,
6 psychiatric, medical, behavioral or other potentially impairing conditions;” and
7

8 Whereas, While PHPs operate in 47 states and the District of Columbia, there are no formal
9 programs in California, Nevada, and Wisconsin; and
10

11 Whereas, PHPs were created with the intention to rehabilitate and monitor physicians with
12 mental illness, physical illness, and substance use disorders; and
13

14 Whereas, PHPs are charged with oversight of licensees who are deemed to be in need of
15 evaluation and/or treatment (namely, those with illnesses that have the potential to interfere with
16 the safe practice of medicine); and
17

18 Whereas, Documentation of untreated “mental illness” is enough to require an evaluation; and
19

20 Whereas, Many psychiatric disorders (including personality disorders or gender identity
21 disorders) do not have a well-defined treatment and may not impact the physician's' ability to
22 carry out their health care obligations; and
23

24 Whereas, PHPs insist that the selection of evaluator(s), whether an individual clinician or a
25 multidisciplinary center should be the responsibility of the PHP, although, if possible the
26 licensee may be allowed to select an evaluator(s) from a PHP-approved list; and
27

28 Whereas, Physicians can be referred to a PHP by their employer, a colleague, a family member,
29 or even themselves; and
30

31 Whereas, PHPs do not provide treatment services, but instead offer long-term case
32 management and monitoring to ensure that physicians follow the program mandated for them;
33 and
34

35 Whereas, Substance use disorder treatment recommended by PHPs typically mandate
36 participation in 12-step programs; and

1 Whereas, Despite the fact that physicians with substance use disorder are forced to partake in
2 12-step programs, research on the efficacy of these programs is mixed and there are other
3 effective programs for substance abuse treatment; and
4

5 Whereas, Physicians must agree to cooperate with the PHP and adhere to any
6 recommendations it makes (including specific treatment type) to avoid disciplinary action and
7 remain in practice; and
8

9 Whereas, PHPs must report to the state licensing board any physician suffering from serious
10 psychiatric illness, drug or alcohol dependence, or any condition it deems to be potentially
11 impairing and may place the public at risk who refuses their recommendation for treatment; and
12

13 Whereas, A recent survey of medical students found they would avoid seeking help for
14 psychological problems for various reasons, including loss of confidentiality (37 percent) and
15 fear of a negative impact on their career (23 percent); and
16

17 Whereas, Two states - North Carolina and Michigan - have already been asked to investigate
18 many of the issues raised by PHP critics; and
19

20 Whereas, The North Carolina audit found that, "physicians may be vulnerable to intimidation
21 because failure to comply with Program directives can result in referral to the North Carolina
22 Medical Board (Medical Board) and the loss of the physician's medical license;" and
23

24 Whereas, The same audit found that the North Carolina PHP had a lack of objective and
25 independent due process procedures, which prevented physicians from successfully appealing
26 against potentially erroneous accusations and evaluations, and in effect were operating outside
27 of the law, a concern echoed in other state PHPs; and
28

29 Whereas, Many of the evaluation and treatment centers to which PHPs refer their clients also
30 sponsor PHP meetings, resulting in a significant potential for conflicts of interest; and
31

32 Whereas, A recent publication in the *Journal of Addiction Medicine* called for national standards
33 for the day-to-day operation of PHPs and for PHPs to be routinely audited to ensure soundness
34 and fairness of practice; and
35

36 Whereas, Due to a lack of consistent funding, participating physicians are forced to pay at least
37 a portion of treatment costs in about half of the available treatment centers; and
38

39 Whereas, 30 of the 43 PHPs in a 2009 survey received a substantial portion of their funding
40 from their state licensing boards, which creates a potential conflict of interest as these PHPs
41 may become beholden to licensing boards rather than risk loss of financial support or closure;
42 and
43

44 Whereas, Although multiple studies show high success rates for PHPs in substance use
45 disorders, they often appear to calculate these success rates by only including patients who a)
46 initially agreed to adhere to the treatment program and b) who were compliant throughout the
47 program - a practice that results in elevated and misleading success rates; and
48

49 Whereas, 'Substantive non-compliance' is considered to be a pattern of non-compliance or
50 dishonesty, or simply an episode of non-compliance (including relapse) which could place
51 patients at risk and result in dismissal from the treatment program; therefore be it

1 RESOLVED, That our American Medical Association amend policy D-405.990, "Educating
2 Physicians About Physician Health Programs," by addition to read as follows:

3
4 1) Our AMA will work closely with the Federation of State Physician Health
5 Programs (FSPHP) to educate our members as to the availability and services of
6 state physician health programs to continue to create opportunities to help ensure
7 physicians and medical students are fully knowledgeable about the purpose of
8 physician health programs and the relationship that exists between the physician
9 health program and the licensing authority in their state or territory; 2) Our AMA will
10 continue to collaborate with relevant organizations on activities that address
11 physician health and wellness; 3) Our AMA will, in conjunction with the FSPHP,
12 develop state legislative guidelines addressing the design and implementation of
13 physician health programs; and 4) Our AMA will work with FSPHP to develop
14 messaging for all Federation members to consider regarding elimination of
15 stigmatization of mental illness and illness in general in physicians and physicians in
16 training; 5) Our AMA will advocate for more independent oversight and regulation of
17 Physician Health Programs (PHPs), by physician groups without any conflict of
18 interest with the participating PHPs; and 6) Our AMA advocate for Physician Health
19 Programs that allow physicians to access more than one type of treatment program.
20 (Modify Current HOD Policy)

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

Received: 10/10/18

RELEVANT AMA POLICY

Educating Physicians About Physician Health Programs D-405.990

1) Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory; 2) Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness; 3) Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs; and 4) Our AMA will work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training.

Citation: (Res. 402, A-09; Modified: CSAPH Rep. 2, A-11; Reaffirmed in lieu of Res. 412, A-12;

Appended: BOT action in response to referred for decision Res. 403, A-12)

Impaired Physicians Practice Act H-275.964

Our AMA encourages state medical societies that do not have effectively functioning impaired physicians programs to improve their programs and to urge their states to adopt the AMA 1985 Model Impaired Physician Treatment Act, as necessary.

Citation: (Sub. Res. 7, A-89; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-97;

Reaffirmed: BOT Rep. 17, I-99; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10)

Confidentiality of Enrollment in Physicians (Professional) Health Programs D-405.984

1. Our American Medical Association will work with other medical professional organizations, the Federation of State Medical Boards, the American Board of Medical Specialties, and the Federation of State Physician Health Programs, to seek and/or support rules and regulations or legislation to provide for confidentiality of fully compliant participants in physician (and similar) health programs or their recovery programs in responding to questions on medical practice or licensure applications.
2. Our AMA will work with The Joint Commission, national hospital associations, national health insurer organizations, and the Centers for Medicare and Medicaid Services to avoid questions on their applications that would jeopardize the confidentiality of applicants who are compliant with treatment within professional health programs and who do not constitute a current threat to the care of themselves or their patients.

Citation: (Res. 4, A-15)

SOURCES

1. Hendin H, Reynolds C, Fox D. Licensing and Physician Mental Health: Problems and Possibilities. Vol 93.; 2007.
2. Federation of State Physician Health Programs. Frequently Asked Questions. Frequently Asked Questions. <https://www.fsphp.org/about/faqs>. Published 2018.
3. Federation of State Medical Boards. Policy on Physician Impairment.; 2011. https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/grpol_policy-on-physicianimpairment.pdf. Accessed January 31, 2018.
4. Candilis PJ. Physician Health Programs and the Social Contract. *AMA J Ethic*. 2016;18(1):77-81. doi:10.1001/journalofethics.2016.18.1.corr1-1601.
5. Dupont RL, McLellan AT, Carr G, Gendel M, Skipper GE. How are addicted physicians treated? A national survey of physician health programs. doi:10.1016/j.jsat.2009.03.010.
6. Ferri M, Amato L, Davoli M. Alcoholics Anonymous and other 12-step programmes for alcohol dependence. *Cochrane Database Syst Rev*. July 2006. doi:10.1002/14651858.CD005032.pub2.
7. Becker SJ, Squires DD, Strong DR, Barnett NP, Monti PM, Petry NM. Training opioid addiction treatment providers to adopt contingency management: A prospective pilot trial of a comprehensive implementation science approach. *Subst Abus*. 2016;37(1):134-140. doi:10.1080/08897077.2015.1129524.
8. Kaskutas LA. Alcoholics Anonymous Effectiveness: Faith Meets Science. *J Addict Dis*. 2009;28(2):145-157. doi:10.1080/10550880902772464.
9. Gibson AM and RL. Addiction, 12-Step Programs, and Evidentiary Standards for Ethically and Clinically Sound Treatment Recommendations: What Should Clinicians Do? *AMA J Ethic*. 2016;18(6):646-655. doi:10.1001/journalofethics.2016.18.6.sect1-1606.
10. Prendergast M, Podus D, Finney J, Greenwell L, Roll J. Contingency management for treatment of substance use disorders: a meta-analysis. *Addiction*. 2006;101(11):1546-1560. doi:10.1111/j.1360-0443.2006.01581.x.
11. Carroll KM, Onken LS. Behavioral therapies for drug abuse. *Am J Psychiatry*. 2005;162(8):1452-1460. doi:10.1176/appi.ajp.162.8.1452.
12. Boyd JW, Knight JR. Ethical and Managerial Considerations Regarding State Physician Health Programs. *J Addict Med*. 2012;6(4):243-246. doi:10.1097/ADM.0b013e318262ab09.
13. Anderson P. Physician Health Programs: More Harm Than Good? *Medscape*. <https://www.medscape.com/viewarticle/849772>. Published 2015. Accessed January 31, 2018.
14. Wood BA. Performance Audit: North Carolina Physicians Health Program, April 2014. Raleigh; 2014. <http://www.ncauditor.net/EPSWeb/Reports/performance/per-2013-8141.pdf>. Accessed February 1, 2018.
15. Boyd JW. A Call for National Standards and Oversight of State Physician Health Programs. *J Addict Med*. 2015;9(6):431-432. doi:10.1097/ADM.0000000000000174.
16. DuPont RL, McLellan AT, White WL, Merlo LJ, Gold MS. Setting the standard for recovery: Physicians' Health Programs. *J Subst Abuse Treat*. 2009;36(2):159-171. doi:10.1016/J.JSAT.2008.01.004.
17. Rose JS, Campbell MD, Yellowlees P, Skipper GE, DuPont RL. Family Medicine Physicians With Substance Use Disorder. *J Addict Med*. 2017;11(2):93-97. doi:10.1097/ADM.0000000000000278.
18. Rose J, Campbell M, Skipper G. Prognosis for Emergency Physician with Substance Abuse Recovery: 5-year Outcome Study. *West J Emerg Med*. 2014;15(1):20-25. doi:10.5811/westjem.2013.7.17871.
19. Skipper GE, Campbell MD, DuPont RL. Anesthesiologists with Substance Use Disorders: A 5-Year Outcome Study from 16 State Physician Health Programs. *Anesth Analg*. 2009;109(3):891-896. doi:10.1213/ane.0b013e3181ad39d.
- 20.

Reference Committee F

BOT Report(s)

- 01 Data Used to Apportion Delegates
- 10 Training Physicians in the Art of Public Forum

CLRPD Report(s)

- 01 Women Physicians Section Five-Year Review

HOD Comm on Compensation of the Officers

- 01* Report of the House of Delegates Committee on Compensation of the Officers

Resolution(s)

- 603* Support of AAIP's Desired Qualifications for Indian Health Service Director

REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-I-18

Subject: Data Used to Apportion Delegates
(Resolution 604-A-18)

Presented by: Jack Resneck, Jr., MD

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

At the 2018 Annual Meeting, Georgia introduced Resolution 604-A-18, “AMA Delegation Entitlements,” which reads as follows:

RESOLVED, That our American Medical Association continue to provide a count of AMA members for AMA delegation entitlements to the House of Delegates as of December 31 and also provide a second count of AMA members within the first two weeks of the new year and that the higher of the two counts will be used for state and national specialty society delegation entitlements during the current year; and be it further

RESOLVED, That the Council on Constitution and Bylaws prepare appropriate language to add a second period of time to determine AMA delegation entitlements to be considered by the AMA House at its earliest opportunity.

The resolution was referred.

The reference committee reported that testimony was largely supportive. Some suggested the opportunity to increase representation in our AMA House of Delegates is used by many delegations in membership recruitment, and delegations believe that seeing the results of their membership recruitment efforts reflected in their delegate counts sooner would further support those efforts.

Following discussion the reference committee was unable to develop a means to implement the method proposed in the resolution and recommended referral to allow a review that focuses on the impact on our entire House of Delegates.

AMA MEMBERSHIP AND DELEGATE APPORTIONMENT BACKGROUND & HISTORY

Article III of the Constitution, “Members,” declares “The American Medical Association is composed of individual members who are represented in the House of Delegates through state associations and other constituent associations, national medical specialty societies and other entities, as specified in the Bylaws.” Individual members are recruited through the efforts of both our AMA and societies in the Federation as well as by current members who solicit their colleagues. The number of individual AMA members in a given society determines the number of delegates under the aforementioned representation in the House of Delegates. (This is true for nearly all societies in the House of Delegates. Under the bylaws, professional interest medical associations and a handful of national societies have a single delegate.)

1 The modern House of Delegates traces to the work of the Committee on Reorganization, which was
 2 established in 1900 and eventuated in the adoption of a new constitution and bylaws in 1901,
 3 redefining and modernizing the House of Delegates (Campion, 1984). Current membership became
 4 the basis for apportioning delegates, as the Committee's work established a House of Delegates based
 5 on proportional representation in which constituent associations were represented on the basis of one
 6 delegate for 500 members. The following year, in June 1902, the House adopted a resolution stating
 7 "That state associations or societies in counting members for a basis of delegate representation in this
 8 House shall count only members in good standing, who pay regular dues to the state association,
 9 either directly or indirectly through county societies."

10
 11 While the ratio of members per delegate has been adjusted over the last 100 plus years to
 12 accommodate growth in the physician population and membership, delegate apportionment has
 13 always been based upon the number of current members. The current ratio of one delegate per 1000
 14 AMA members dates from 1946. The 1948 constitution prescribed that the "number of delegates from
 15 the constituent associations shall be proportional to the number of active members in the respective
 16 associations," and that year saw the start of the annual apportionment process.

17
 18 Two significant changes were effected in the early 1950s. At the December 1950 meeting, the
 19 members to be counted were explicitly defined to be AMA members: "The apportionment of
 20 delegates from each constituent association shall be one delegate for each thousand (1,000) or fraction
 21 thereof, *dues paying active members of the American Medical Association* (emphasis added)."
 22 Whereas before this time counts focused on members of the constituent associations, now the relevant
 23 population was specified to be AMA members.* At the 1952 Annual Meeting, December 31 was set
 24 as the cutoff date for counting members to maximize the time allowed for societies to add members,
 25 with the effective date for apportionment January 1 (Proceedings of the House of Delegates, 1952).

26
 27 Irrespective of how or when members join our AMA, under our current bylaws delegates are
 28 apportioned to constituent societies and national medical specialty societies at the rate of one delegate
 29 per 1000, or fraction thereof, AMA members as of December 31.[†] That is, one must be a member on
 30 December 31 to be counted for apportionment purposes. The apportionment is effective January 1 of
 31 the following year and is effective for one year. (See bylaws 2.1.1 and 2.2.1 and subsections.) Thus,
 32 for example, if a society has 1000 AMA members on December 31, it will be apportioned one
 33 delegate for the following year. A society with 1001 members will be apportioned two delegates.
 34 (Although they are endorsed by and seated with constituent and national medical specialty societies
 35 seated in the House of Delegates, separate bylaws provisions address the regional medical student and
 36 sectional resident delegates who are apportioned differently.)

37
 38 Because of differences in data availability and because delegate apportionment for constituent
 39 societies determines the overall delegate apportionment for national medical specialty societies,
 40 characterizations below are couched in terms of constituent societies. Figures for those societies are
 41 also more easily captured in real time.

* To be clear, under the 1901 constitutional revision, AMA membership was granted to all members of local medical societies affiliated with state medical societies who applied for membership, supplied certification and paid the annual fee. In 1899, the annual dues were \$10 (*Caring for the Country*, 1997, pages 40-41).

[†] Member counts for constituent (ie, geographic) societies are determined annually. The overall number delegates apportioned to constituent societies determines the total number of delegates apportioned to national medical specialty societies, with the number of delegates apportioned to any particular specialty society *generally* tied to that society's most recent five-year review.

1 APPORTIONMENT UNDER RESOLUTION 604

2
3 As written, Resolution 604-A-18 calls for two enumerations of AMA membership, with the first
4 being the usual year-end calculation and the second being a count of members in approximately mid-
5 January. The larger of the two figures would be used for delegate apportionment. Unspecified is who
6 would be counted in the mid-January enumeration. While the count should clearly include those
7 whose now current year's dues have been paid, it should properly exclude individuals who have not
8 paid their appropriate dues by mid-January, as knowing who will (or will not) renew their
9 membership is not possible. A substantial number of members unfortunately do not renew annually,
10 and many members pay their current year dues after mid-January. Given these factors it seems likely
11 that a mid-January count of current year dues paying members would almost certainly be lower than
12 the year end count.

13
14 Calculations by AMA's Membership Group suggest that the magnitude of the difference of the two
15 counts would depend on the date of the second count. The largest number of AMA members is
16 recruited through AMA's own direct channel, and in any given year the vast majority of current year
17 members have typically joined by February. Consequently, one might advocate for a count in early
18 March or later, but even such a later count would exclude members who join later in the year,
19 particularly the large number of medical students and residents who typically join in summer or fall.
20 Pushing the count to a later date would also shorten the time for societies to adjust their delegation
21 size when necessary.

22
23 In light of the ambiguity regarding who would be counted, prior to June's House of Delegates
24 meeting Georgia, the sponsor of Resolution 604-A-18, proposed that the first resolve would be
25 implemented by counting for apportionment purposes current nonmembers who join the AMA for the
26 succeeding year during the current year. That discussion as well as comments during the reference
27 committee hearing suggested a revision of the first resolve to call for "the number of new AMA
28 members who have already paid their dues for a membership that officially begins on January 1 of the
29 following year will be included in the annual year-end count of AMA members, for the purposes of
30 AMA Delegation entitlements for state and national specialty societies for that following year." For
31 example, a nonmember in 2018 who during calendar year 2018 joins (and pays dues) for the 2019
32 membership year would be counted as a member in apportioning delegates for the 2019 calendar
33 year. Hereinafter these are referred to as "pending members," as their active membership is still
34 pending on December 31.

35 Whether any particular society would benefit from such a change would depend on whether the
36 inclusion of pending members would carry it over a one thousand threshold. For those societies that
37 gain a delegate, the increased representation would, other things being equal, be a one-time increase.
38 That is because each year some current members choose not to renew their memberships. While they
39 factor into the annual delegate apportionment process as current members, they drop out of the
40 calculations at the end of the subsequent year, and unless the pending members consistently
41 outnumber the non-renewing members, the gain would likely be a one-time event.

42
43 Data from year-end 2017, which were used for delegate allocation in 2018, indicate that five states
44 would have gained a delegate this year if pending members had been included. The states that would
45 gain in the future, however, depend on whether the addition of pending members pushes them across
46 the threshold for an additional delegate. For example, only two of the four states currently needing
47 fewer than 100 pending members to gain a delegate position would benefit, while among the 10 states
48 that had the largest number of pending members (range 261–691) at the end of 2017, only the first
49 and third largest would have picked up a delegate. The other three states that would have added a
50 delegate using this method at the end of 2017 did not have the largest number of pending members,
51 but the figure would push them over the additional delegate threshold. In other words, it would be the

1 combination of pending members and actual members that determines which states would benefit
2 from the change, adding an element of chance to the apportionment process.

3 4 DISCUSSION

5
6 Other than changes due the inclusion of more societies in the House of Delegates (and discounting
7 freezes), the rules for apportioning delegates to constituent societies have remained essentially
8 unchanged since 1952. For over a century, the apportionment rules have been based on current
9 membership, and for seventy years it has been recognized that apportionment should be conducted
10 annually to address membership fluctuations.

11
12 Another issue related to the counting of members warrants further discussion. Counting pending
13 members, individuals who “join” our AMA at the end of a current year but whose memberships are
14 not effective until the following year, means that one membership for AMA purposes effectively
15 counts for two years membership for delegate allocation purposes. In addition, this could result in
16 counting members for apportionment purposes that subsequently request a refund and are therefore
17 never actual dues paying members in either year. Gaming of such a system would be possible, with
18 for example panels of one-year members joining in alternate years or signing up for membership and
19 then requesting a refund, which is generally provided upon request in the first half of a calendar year.

20
21 Membership accounting can only allocate the membership to the year for which dues are paid, so
22 membership figures used for apportionment figures that include pending members would be
23 inconsistent with figures reported in our AMA’s annual report. Both the apportionment figures and
24 the official membership numbers are publicly available on the AMA website, which would require
25 the divergent apportionment figures to include an explanatory note. It might also be noted that
26 adjustments are not made during the year for losses such as deaths, resignations or CEJA actions that
27 remove an individual from the membership rolls.

28
29 While no effort to recruit members to our AMA should be discounted, among current members the
30 most often cited reason for belonging to our AMA is advocacy on behalf of the profession. This has
31 been true for many years, and although the value of enhanced representation in the House of
32 Delegates is often promoted to prospective members, little evidence supports the idea that physicians
33 join our AMA because of the House of Delegates per se. Rather, the advocacy that stems from House
34 actions is the more valued commodity. Indeed, the average physician—member or not—knows little
35 about the House of Delegates and AMA policymaking processes. The prospect of enhanced
36 representation may be a serviceable argument in the member recruitment quiver, but more successful
37 appeals address current AMA activities dealing with critical matters of public health, medical
38 education, practice sustainability and advocacy. Our AMA’s current Members Move Medicine™
39 campaign is based on this well-established foundation. The current apportionment system occurring at
40 the end of the year recognizes the recruitment that occurs throughout the year, including the
41 significant recruitment of medical students and residents that typically occurs well into the year.

42
43 Finally, some costs would be associated with the change. Our AMA would incur the expense of
44 rebuilding the counting procedures and maintaining the distinct records necessary for membership
45 accounting and apportionment processes. The associated complexity and expense would be greater if
46 the selected methodology demanded counting pending and current members rather than a simple
47 change in date of apportionment. Societies in the House of Delegates could incur the intangible cost
48 of some uncertainty in the number of delegates, which would depend on the counting scheme actually
49 adopted, along with the real expense of supporting additional delegates. None of these costs are easily
50 quantified.

51 RECOMMENDATION

1
2 The decision to count pending members for delegate apportionment purposes is clearly within the
3 purview of the House. It would require revisions of the bylaws before it can be implemented with
4 issues of how to handle those who join and those who no longer are AMA members during a calendar
5 year after a fixed point in time of deciding HOD apportionment has occurred.[‡] The apparent concern
6 about disenfranchising a new AMA member whose membership is effective after apportionment is
7 readily addressed through the online member forums. With access to online member forums before
8 HOD meetings, that AMA member can have active voice and influence in AMA policymaking.
9

10 The House of Delegates has for over a century counted only current members (ie, dues paid and
11 received by AMA) in determining delegate apportionment. The idea that pending members should be
12 added to the current membership seems unwarranted. It effectively double counts individuals, counts
13 members who may or may not rejoin, artificially increases the size of the House of Delegates by
14 including nonmembers in determining representation among Federation societies, and creates
15 opportunities for abuse. Insofar as these pending members will be counted for apportionment
16 purposes for the next cycle when they are actually members, arguments about fairness and
17 representation seem overstated. Finally, under current bylaws any constituent society that may lose a
18 delegate based upon the previous year final count is given a full year to recruit and retain members to
19 retain their delegate count. For these reasons, the Board of Trustees recommends that Resolution
20 604-A-18 not be adopted and the remainder of this report be filed.

Fiscal note: None

[‡] Some bylaws issues are not clear cut. Bylaw 2.1.1.1.1, for example, allows a constituent society to retain a delegate in the event of a loss of AMA members. Whether so called “pending members” should be allowed to offset losses in “actual members” certainly merits discussion.

REFERENCES

Campion FD. *The AMA and US Health Policy since 1940*. Chicago: Chicago Review Press. 1984. See especially Chapter 7.

Caring for the Country: A History and Celebration of the first 150 years of the American Medical Association. American Medical Association, Chicago 1997

Proceedings of the House of Delegates, One Hundred and First Annual Session. Chicago: American Medical Association. 1952.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-I-18

Subject: Training Physicians in the Art of Public Forum
(Resolution 606-A-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

1 INTRODUCTION

2
3 At the 2018 Annual Meeting, the House of Delegates referred Resolution 606 as introduced by the
4 delegation from New Jersey to the Board of Trustees, to investigate a proposal that the AMA
5 should “establish a program for training physicians in the art and science of conducting public
6 forums in order to ensure that the public is well informed on the health care system of our country.”
7

8 Within the reference committee, there was considerable supportive testimony about the need to
9 improve physicians’ ability to speak publicly. Several who testified believed that the resources
10 needed to undertake training in public speaking are already available throughout the Federation and
11 could be utilized instead of creating new training materials. However, others believed that
12 developing the ability of physicians to positively present themselves in the public arena is too
13 important to leave to other organizations, and that training in public speaking could be offered as a
14 valuable AMA member benefit.
15

16 In evaluating the goal and the desired outcome, it is important to survey the existing landscape of
17 resources available to physicians to help inform AMA’s approach.
18

19 BACKGROUND

20
21 The leading organization that assists individuals with public speaking and leadership development
22 is Toastmasters International. Individuals can improve their speaking and leadership skills by
23 attending one of the 16,400 clubs worldwide. By regularly giving speeches and receiving feedback,
24 individuals can learn to tell their stories and leverage their voices.
25

26 AMPAC, the bipartisan political action committee of the American Medical Association, provides
27 high level training to physicians who are considering pursuit of elected office. For those who want
28 to campaign for public office and advocate for issues important to patients and physicians, this is a
29 premiere training program and valuable resource for physicians.
30

31 Other general communication resources available by the AMA include STEPS Forward modules
32 on topics like “Conducting Effective Team Meetings” and “Implementing a Daily Team Huddle.”
33

34 Within the Federation, several physician groups provide opportunities for training on effective
35 communications, including the American College of Physicians, American Academy of Family
36 Physicians, and the American Medical Women’s Association.

1 Perhaps the leader in providing this training to physicians is the American Association of Physician
2 Leadership (AAPL). Training topics offered by this organization include: “Present like a Pro,”
3 “Delivering Effective Feedback,” “Fundamentals of Physician Leadership: Communication,” and
4 “Improving Communication and Feedback in Healthcare Leadership.” Courses are offered online
5 or in-person. Many of the self-study courses offer the option to watch the video lectures or attend
6 the sessions. A majority of the courses are accessible for up to three years after purchase. The
7 organization also offers live education courses that allow physicians to network with their peers.
8 There are also faculty-led courses that allow physicians to participate in discussions and case
9 studies throughout a six-week class session.

10 11 RECOMMENDATION

12
13 Physicians who want to learn more about public speaking can leverage existing resources both
14 within and outside the AMA. AMA can make public speaking tips available through online tools
15 and resources that would be publicized on our website. Physicians and physicians-in-training who
16 want to publicly communicate about the AMA’s ongoing work are invited to learn more through
17 the AMA Ambassador program.

18
19 Meanwhile, STEPS Forward provides helpful tips to physicians wanting to improve
20 communication within their practice and AMPAC is available for physicians who want to advocate
21 and communicate about the needs of patients and physicians in the pursuit of public office. There
22 are also resources provided to physicians at various Federation organizations and through AAPL to
23 support those who are interested in training of this nature.

24
25 Because public speaking is a skill that is best learned through practice and coaching in a small
26 group or one-on-one setting, we also encourage individuals to pursue training through their state or
27 specialty medical society or through a local chapter of Toastmasters International.

28
29 The Board of Trustees recommends that the AMA’s Enterprise Communications and Marketing
30 department work to develop online tools and resources that would be published on the AMA
31 website to help physicians learn more about public speaking in lieu of Resolution 606-A-18 and the
32 remainder of the report to be filed. (Directive to Take Action)

Fiscal Note: \$20,000 for professional fees for external support and capacity to develop these tools
and resources.

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-I-18

Subject: Women Physicians Section Five-Year Review

Presented by: Alfred Herzog, MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

1 AMA Bylaw 7.0.9 states, “A delineated section must reconfirm its qualifications for continued
2 delineated section status and associated representation in the House of Delegates by demonstrating
3 at least every 5 years that it continues to meet the criteria adopted by the House of Delegates.”
4 AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and
5 Development (CLRPD) is “to evaluate and make recommendations to the House of Delegates,
6 through the Board of Trustees, with respect to the formation and/or change in status of any section.
7 The Council will apply criteria adopted by the House of Delegates.”
8

9 The Council analyzed information from the letter of application submitted by the Women
10 Physicians Section (WPS) for renewal of delineated section status.
11

12 APPLICATION OF CRITERIA TO THE WOMEN PHYSICIANS SECTION

13
14 Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within
15 the broader, general issues that face medicine. A demonstrated need exists to deal with these
16 matters, as they are not currently being addressed through an existing AMA group.
17

18 The WPS is the only AMA group that is dedicated to advocacy on women physician policy issues,
19 providing leadership development and educational opportunities for women, and monitoring trends
20 and issues that affect women in medicine and women’s health. Currently, the WPS represents more
21 than 82,000 AMA women members. According to 2017 data from the Association of American
22 Medical Colleges, the number of women enrolling in U.S. medical schools has exceeded the
23 number of men. Since 2015, the number of female matriculants has grown by 9.6%, while the
24 number of male matriculants has declined by 2.3%.
25

26 The WPS addresses three major concerns: 1) women in medicine professional issues, which
27 include discrimination, e.g., gender bias and income disparity; 2) under-representation of women
28 physicians in leadership positions in organized medicine and academic medicine, which includes
29 disproportionate representation of women physicians in the AMA House of Delegates (HOD); and
30 3) health issues that disproportionately or uniquely affect women patients.
31

32 CLRPD assessment: The mission of the WPS is to provide a dedicated forum within the AMA to
33 increase discussion of and advocacy on women physician issues and strengthen the AMA’s ability
34 to represent this physician constituency. The WPS provides advice and counsel to the Association
35 on policy and program issues of interest to women physicians, and offers suggestions for activities
36 that best meet the needs of this physician segment. No other groups or sections within the AMA
37 specifically address the unique issues of concern of women physicians and patients.

1 Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the
2 AMA. Activities make good use of available resources and are not duplicative.

3
4 Over the past five years, the WPS has aligned its strategic goals with the AMA to find ways to
5 promote the efforts of the three strategic arcs. The Section's educational programs were in
6 support of topics that highlighted AMA priority issues such as physician burnout, continuing
7 education, and the opioid epidemic. Overall, the WPS supports the AMA's objectives by
8 reviewing new AMA products and services, providing insights on policy and advocacy
9 positions, and creating new ways to reach out to members and potential members.

10
11 The WPS collaborates with other groups to help improve the impact of the Section's key goals.
12 During the 2017 Annual Meeting of the HOD, the WPS collaborated with the Medical Student
13 Section to offer two programs: 1) a session that allowed medical students to connect with WPS
14 Governing Council (GC) members to discuss such topics as choosing a residency, communicating
15 with patients, developing leadership skills, critical decision making, careers in academic medicine,
16 and contract negotiation; and 2) "Occupational Health through a Gender-Conscious Lens." The
17 WPS has collaborated with other AMA sections on educational offerings: the WPS, Integrated
18 Physician Practice Section, and Organized Medical Staff Section program, "Transforming Roles in
19 Healthcare Leadership: How physicians can effectively communicate with non-physician leaders";
20 and the multi-sections' program, "Gun Violence: What do we know? What can physicians do?"

21
22 Additionally, the WPS leads the AMA's Women in Medicine Month each September. During this
23 time, the WPS implements two major programs:

- 24
25 1. Inspirational Physicians Recognition Program (formerly the Physician Mentor Recognition
26 Program). The WPS provides an opportunity for physicians to express appreciation to the
27 special men and women who have offered time, wisdom and support throughout their
28 professional journeys.
29 2. Joan F. Giambalvo Fund for the Advancement of Women (formerly the Giambalvo
30 Memorial Scholarship Fund). The AMA Foundation in association with the WPS
31 established the Fund with the goal of advancing the progress of women in the medical
32 profession, and strengthening the ability of the AMA to identify and address the needs of
33 women physicians and medical students.

34
35 In 2016, the WPS hosted its Women in Medicine Symposium at AMA headquarters, which
36 included presentations, panel discussions and breakout sessions covering physician resiliency and
37 burnout, overcoming obstacles in daily practice, and physician wellness techniques.

38
39 Over the last five years, the Section has worked collaboratively with various physician groups to
40 expand the influence of the WPS. Some of these efforts have included strong working relationships
41 with the leadership of other sections, representation on the AMA Alliance's Women in Medicine
42 Task Force, and the renaming and expansion of the liaisons program to the WPS Associates
43 Program.

44
45 CLRPD Assessment: The WPS serves its constituents by bringing professional issues unique to
46 women physicians to the forefront of organized medicine, and by providing targeted educational
47 programs and resources for the policymaking process.

48
49 Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and
50 activities.

The WPS GC is structured as an eight-member group elected by the WPS membership. Designated positions on the GC are delegate, alternate delegate, member-at-large (2), Medical Student Section representative, Resident and Fellow Section representative, Young Physicians Section representative, and American Medical Women's Association representative.

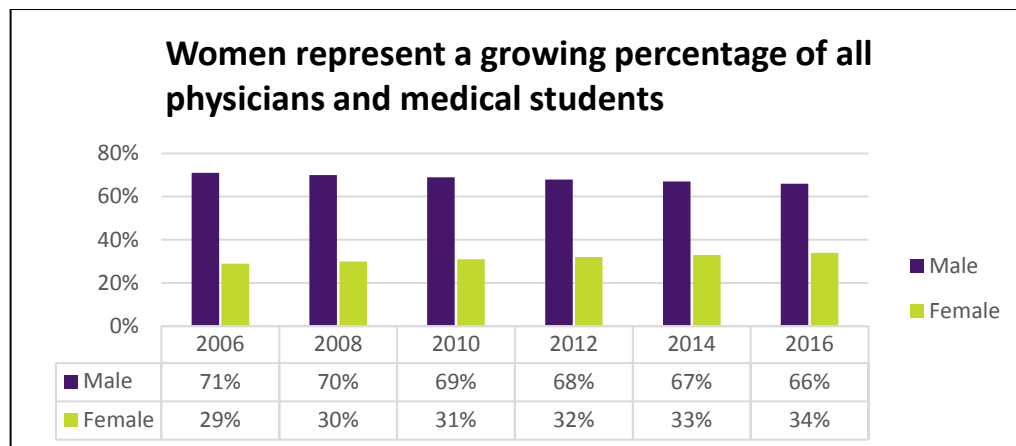
All members of the WPS are eligible to be elected to any office, except the member at-large positions that may not be assumed by medical students. If a candidate is serving on a HOD delegation, they must be willing to resign from their respective HOD delegation position if elected as the WPS delegate or alternate delegate. Lastly, the GC elects its chair and vice chair for the upcoming year in a closed session at each Annual HOD Meeting.

The WPS is developing a five-year strategic plan to assess the progress that the Section has made in advancing women in the medical profession, strengthening the ability of the AMA to address the needs of women physicians and medical students, and what WPS hopes to achieve by 2023.

CLRPD Assessment: The WPS convenes a GC from its members and holds strategic planning meetings to plot its annual and long-term goals, and ensure alignment with the goals of the AMA. All Section members have opportunities throughout the year to contribute to the deliberations of the WPS either in person or by virtual means such as HOD Online Forums, listservs, Twitter and special interest Facebook groups.

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

According to CLRPD Report 1-A-07, Demographic Characteristics of the House of Delegates and AMA Leadership, in 2006, 309,617 (29%) of U.S. physicians and medical students were female, and comprised 25.6% of AMA members. When the Women Physicians Congress became a section in 2013, CLRPD Report 2-A-13 indicated a growing number of female physicians and medical students (380,050), which comprised 31.3% of AMA members. According to CLRPD Report 2-A-17, there are 82,491 female AMA members (34.3% of AMA membership) and women make up 34.0% of all U.S. physicians and medical students. According to the same CLRPD report, there are 435,099 women physicians and medical students in the United States. Thus, WPS membership comprises 19% of this physician segment.



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

Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this Section and both the segment and the AMA will benefit from an increased voice within the policymaking body.

AMA Bylaw 7.10.1 states, "All female physicians and medical students who are active members of the AMA shall be eligible to be members of the Women Physicians Section. Other active members of the AMA who express an interest in women's issues shall be eligible to join the Section."

Based on AMA Physician Engagement's analysis, the WPS unit experienced a 5% increase of interactions with women physicians and medical students from 2015 to 2016. Overall, the following changes drove improvement:

1. The Women Physicians Congress transitioned from an advisory group to the WPS in 2013.
2. WPS members have the ability to create policy and have a voice in the HOD.
3. The AMA increased communication directed at women physicians.
4. All WPS members with a valid email address in the AMA's database receive a monthly newsletter from the Section.
5. WPS members are encouraged to contribute to the policymaking processes of the Section and provide input into programs and products.

Additionally, the WPS developed a social media plan to further member engagement efforts. During the 2016 Women in Medicine month:

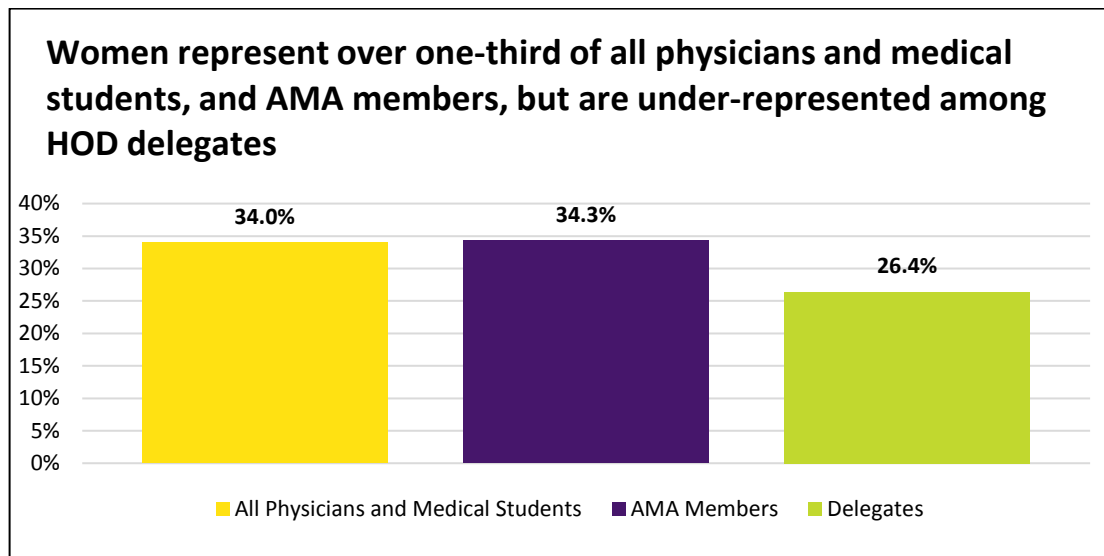
- Facebook posts totaled 1,186,889 impressions and 14,950 acts of engagement, reflecting 31% and 25% increases over 2015 numbers, respectively.
- Twitter posts totaled 287,665 impressions, reflecting a 21% increase over 2015 numbers.
- The WPS webpage experienced a 34% increase in traffic compared to the previous year. Similarly, there was a 16% increase in traffic to the Women In Medicine webpage in 2016.

In the 2017 GC elections, 1,732 WPS members voted. The number of voters has increased every year. During the first WPS election in 2015, 936 WPS members took part in the election. Nominations for leadership positions were also up by 35% over last year. This increase was driven by promotional efforts in *AMA Wire*, targeted outreach to the Federation, and the identification of new communication channels such as the Women in Otolaryngology Listserv and special interest Facebook groups.

CLRPD Assessment: WPS meetings, elections, and educational sessions are well attended, and demonstrate increasing engagement, while strategies are in place to further grow participation. The population of potential WPS members continues to expand. The AMA has benefited from an increased voice of WPS members within the policymaking body of the Association.

Criterion 6: Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the HOD.

From 2008 to 2016, the percentage of female delegates increased from 19.3% to 26.4%. While this increase is important, in 2016, women represented 34% of all U.S. physicians and medical students, and 34.3% of all AMA members. However, just 26.4% of delegates and 28.4% of alternate delegates were female, which indicates this segment is under-represented in the HOD.



The WPS policymaking process begins with an open call to the Section's membership for resolutions. Concurrently, the WPS policy committee works to identify topics for potential resolutions. Resolutions are vetted by WPS staff and the AMA legal team. Accepted resolutions are presented to the Section's membership for comment via an online forum. The WPS GC reviews the comments and approved resolutions are placed online for ratification. Ultimately, the ratified resolutions are submitted to the HOD.

The WPS convenes a HOD Handbook Review Committee prior to each HOD meeting. The process involves several members of the WPS who evaluate all resolutions and reports under consideration. The Committee usually reaches consensus on 95% of the items and the GC determines the Section's position on the remaining 5%. During the WPS business meeting, the delegate and alternate provide an open forum to discuss the Section's active positions on HOD items of business. All attendees are welcome to participate and provide insights on reports and resolutions. The process allows for discussion and development of a position, to support, monitor or oppose, which guides the delegate and alternate delegate as they testify on behalf of the Section. The WPS typically submits 3-4 resolutions to the HOD per meeting. Over the past four years, the Section has introduced 20 resolutions to the HOD.

Over the past four years, the Section has submitted resolutions related to WPS topics of concern: Tubal Ligation and Vasectomy Consents, Impact of Pharmaceutical Advertising on Women's Health, A New Definition of "Women's Health," Off-Label Use of Hormone Therapy, Heart Disease and Women, Medical Necessity of Breast Reconstruction and Reduction Surgeries, Women and Alzheimer's Disease, Women and Pre-exposure prophylaxis (PrEP), Women and Mental Health, Research into Preterm Birth and Related Cardiovascular (CV) and Cerebrovascular

1 Risks (CVD) in Women, and Care of Women and Children in Family Immigration Detention.
2 Eighty-two percent of WPS submitted resolutions resulted in development of new AMA policy or
3 amendment of existing policy. The WPS provides its members with an opportunity to become
4 involved in the Section's HOD activities, such as delivering testimony on behalf of the Section
5 during reference committee hearings.

6
7 Overall, the WPS presents the AMA with the unique policy perspective of its women physician
8 members. The Section brings to the forefront key areas of need in relation to women physicians
9 and women's health concerns. For example, the WPS introduced and the HOD adopted the
10 resolution, Interventions for Opioid Dependent Pregnant Women (A-16). During the 2017 Annual
11 Meeting, the Section hosted an educational session, "Responding to the Impact of the Opioid
12 Epidemic on Women" and is supporting the efforts of the AMA's Task Force to Reduce Opioid
13 Abuse. During the 2015 Annual Meeting, the WPS submitted the resolution, Human Trafficking
14 Reporting and Education, that the HOD adopted, and the AMA used to provide testimony for a
15 Congressional Committee.

16
17 CLRPD Assessment: The WPS provides numerous opportunities for members of the constituency
18 to introduce issues of concern and participate in the HOD policymaking process. The WPS has
19 continually pursued ways to improve member communications and the resolution process; thereby,
20 encouraging member involvement. The WPS provides a formal structure for women physicians to
21 participate directly in the deliberations of the HOD and impact policy.

22 23 RECOMMENDATION

24
25 The Council on Long Range Planning and Development recommends that our American Medical
26 Association renew delineated section status for the Women Physicians Section through 2023 with
27 the next review no later than the 2023 Interim Meeting and that the remainder of this report be
28 filed. (Directive to Take Action)

Fiscal Note: Less than \$500

REPORT OF THE HOUSE OF DELEGATES COMMITTEE
ON THE COMPENSATION OF THE OFFICERS

Comp. Comte. Report I-18

Subject: Report of the House of Delegates Committee on Compensation of the Officers

Presented by: Marta J. Van Beek, MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

1 This report by the Committee at the 2018 Interim Meeting presents one recommendation. It also
2 documents the compensation paid to Officers for the period July 1, 2017 thru June 30, 2018 and
3 includes the 2017 calendar year IRS reported taxable value of benefits, perquisites, services, and
4 in-kind payments for all Officers.

5
6 BACKGROUND

7
8 At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on
9 Trustee Compensation, currently named the Committee on Compensation of the Officers, (the
10 "Committee"). The Officers are defined in the American Medical Association's (AMA)
11 Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the
12 HOD, Article V refers simply to "Officer," which includes all 21 members of the Board among
13 whom are President, President-Elect, Immediate Past President, Secretary, Speaker of the HOD and
14 Vice Speaker of the HOD, collectively referred to in this report as Officers.) The composition,
15 appointment, tenure, vacancy process and reporting requirements for the Committee are covered
16 under the AMA Bylaws. Bylaws 2.13.4.5 provides:

17
18 The Committee shall present an annual report to the House of Delegates recommending the
19 level of total compensation for the Officers for the following year. The recommendations of
20 the report may be adopted, not adopted or referred back to the Committee, and may be
21 amended for clarification only with the concurrence of the Committee.

22
23 At A-00, the Committee and the Board jointly adopted the American Compensation Association's
24 definition of total compensation which was added to the Glossary of the AMA Constitution and
25 Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an
26 individual for work performance including: (a) all forms of money or cash compensation; (b)
27 benefits; (c) perquisites; (d) services; and (e) in-kind payments.

28
29 Since the inception of this Committee, its reports document the process the Committee follows to
30 ensure that current or recommended Officer compensation is based on sound, fair, cost-effective
31 compensation practices as derived from research and use of independent external consultants,
32 expert in Board compensation. Reports beginning in December 2002 documented the principles
33 the Committee followed in creating its recommendations for Officer compensation.

34
35 At A-08, the HOD approved changes that simplified compensation practices with increased
36 transparency and consistency. At A-10, Reference Committee F requested that this Committee

1 recommend that the HOD affirm a codification of the current compensation principle, which
2 occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base
3 its recommendations for Officer compensation on the principle of the value of the work performed,
4 consistent with IRS guidance and best practices as recommended by the Committee's external
5 independent consultant, who is expert in Board compensation.
6

7 At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation
8 with that of all other Officers (excluding Presidents and Chair) because these positions perform
9 comparable work.
10

11 Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves
12 Group, to update his 2007 research by providing the Committee with comprehensive advice and
13 counsel on Officer compensation. The updated compensation structure was presented and
14 approved by the HOD at I-11 with an effective date of July 1, 2012.
15

16 The Committee's I-13 report recommended and the HOD approved the Committee's
17 recommendation to provide a travel allowance for each President to be used for upgrades because
18 of the significant volume of travel in representing our AMA.
19

20 At I-16, based on results of a comprehensive compensation review conducted by Ms. Becky Glantz
21 Huddleston, an expert in Board Compensation with Willis Towers Watson, the Committee
22 recommended and the HOD approved modest increases to the Governance Honorarium and Per
23 Diems for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. A-
24 17's report, approved by the HOD, modified the Governance Honorarium and Per Diem definition
25 so that Internal Representation, in excess of eleven days, receives a per diem.
26

27 At A-18, based on a compensation review focused on the Presidents' and Chairs' compensation,
28 the Committee recommended and the House approved a modest increase to their Honoraria, the
29 first increase in ten years.
30

31 CASH COMPENSATION SUMMARY

32

33 The cash compensation of the Officers shown in the following table will not be the same as
34 compensation reported annually on the AMA's IRS Form 990 because Form 990s are based on a
35 calendar year. The total cash compensation in the summary is compensation for the days these
36 Officers spent away from home on AMA business approved by the Board Chair. The total cash
37 compensation in the summary includes work as defined by the Governance Honorarium and Per
38 Diem for Representation including conference calls with groups outside of the AMA, totaling 2
39 hours or more per calendar day as approved by the Board Chair. Detailed definitions are in the
40 Appendix.

1 The summary covers July 1, 2017 to June 30, 2018

AMA Officers	Position	Total Compensation	Total Days
Maya A Babu, MD, MBA	Resident Officer	\$ 5,400	0
Susan R Bailey, MD	Speaker, House of Delegates	\$ 96,850	50.5
David O Barbe, MD, MHA	President	\$ 279,000	161
Willarda V Edwards, MD, MBA	Officer	\$ 67,600	48
Jesse M Ehrenfeld, MD, MPH	Secretary & Young Physician Officer	\$ 131,650	90
E Scott Ferguson, MD	Officer	\$ -	2.5
Sandra A Fryhofer, MD	Officer	\$ -	4
Andrew W Gurman, MD	Immediate Past President	\$ 274,000	98
Gerald E Harmon, MD	Chair	\$ 269,500	91.5
Patrice A Harris, MD, MA	Immediate Past Chair	\$ 150,600	120.5
William E Kobler, MD	Officer	\$ 92,950	63
Russell WH Kridel, MD	Officer	\$ 70,200	47
Barbara L McAneny, MD	President-Elect	\$ 274,000	135
William A McDade, MD, PhD	Officer	\$ 74,100	60
Mario E Motta, MD	Officer	\$ -	2
S Bobby Mukkamala, MD	Officer	\$ 65,000	43.5
Albert J Osbahr, III, MD	Officer	\$ 78,000	54.5
Stephen R Permut, MD, JD	Officer	\$ 89,050	68
Jack Resneck, Jr, MD	Chair-Elect	\$ 199,500	94.5
Ryan J Ribeira, MD, MPH	Resident Officer	\$ 66,300	39
Karthik V Sarma, MS	Medical Student Officer	\$ 102,050	85.5
Bruce A Scott, MD	Vice Speaker, House of Delegates	\$ 78,650	55.5
Carl A Sirio, MD	Officer	\$ 106,600	78.5
Georgia A Tuttle, MD	Officer	\$ 85,800	60.5
Kevin W Williams, MSA	Public Board Member Officer	\$ 65,000	43.5

2 President, President-Elect, Immediate Past President and Chair

3 In 2017-2018, each of these positions received an annual Governance Honorarium which was paid
4 in monthly increments. These four positions spent a total of 485.5 days on approved Assignment
5 and Travel, or 121.4 days each on average.

6

7 Chair-Elect

8 This position received a Governance Honorarium of approximately 75% of the Governance
9 Honorarium provided to the Chair.

10

11 All other Officers

12 All other Officers received cash compensation, which included a Governance Honorarium of
13 \$65,000 paid in monthly installments. The remaining cash compensation is for Assignment and
14 Travel Days that are approved by the Board Chair to externally represent the AMA. These days
15 were compensated at a per diem rate of \$1,300.

16

17 Assignment and Travel Days

18 The total Assignment and Travel Days for all Officers (excluding the President, President-Elect,
19 Immediate Past President and Chair) were 1110.5; this includes reimbursement for telephonic
20 representation meetings for external organizations that are 30 minutes or longer during a calendar
21 day and total 2 or more hours. These are reimbursed at ½ of the current per diem rate. During this
22 reporting period, there were 18 reimbursed calls, representing 9 per diem days.

1 EXPENSES

2
3 Total expenses paid for the period, July 1, 2017 – June 30, 2018, \$798,212 compared to \$844,506
4 for the previous period, representing a 5.5% decrease. This includes \$1,907 in upgrades for
5 Presidents' travel per the approved Presidential Upgrade Allowance of \$2,500 per position per
6 term.

7
8 BENEFITS, PERQUISITES, SERVICES AND IN-KIND PAYMENTS

9
10 Officers are able to request benefits, perquisites, services and in-kind payments, as defined in the
11 "AMA Board of Trustees Standing Rules on Travel and Expenses." These non-taxable business
12 expense items are provided to assist the Officers in performing their duties:

- 13
14
 - AMA Standard laptop computer or iPad
 - 15 • iPhone
 - 16 • American Express card (for AMA business use)
 - 17 • Combination fax/printer/scanner
 - 18 • An annual membership to the airline club of choice offered each year during the Board
 - 19 member's tenure
 - 20 • Personalized AMA stationery, business cards and biographical data for official use.

21

22 Additionally, all Officers are eligible for \$305,000 term life insurance and are covered under the
23 AMA's \$500,000 travel accident policy and \$10,000 individual policy for medical costs arising out
24 of any accident while traveling on official business for the AMA. Life insurance premiums paid by
25 the AMA are reported as taxable income. Also, travel assistance is available to all Officers when
26 traveling more than 100 miles from home or internationally.

27
28 Secretarial support, other than that provided by AMA's Board office, is available up to defined
29 annual limits as follows: President, during the Presidential year, \$15,000; \$5,000 each for the
30 President-Elect, Chair, Chair-Elect and Immediate Past president per year. Secretarial expenses
31 incurred by other Officers in connection with their official duties are paid up to \$750 per year per
32 Officer. This is reported as taxable income.

33
34 Travel expenses incurred by family members are not reimbursable, except for the family of the
35 incoming President at the Annual Meeting of the HOD.

36
37 Calendar year taxable life insurance and taxable secretarial fees reported to the IRS totaled \$28,791
38 and \$28,750 respectively for 2017. An additional \$5,750 was paid to third parties for secretarial
39 services during 2017.

40
41 METHODOLOGY

42
43 Periodically, the issue of health insurance for the Presidents has been brought to this Committee's
44 attention. Specifically, what our AMA can do to assist our President(s) when replacement health
45 insurance is needed because he/she loses health insurance coverage at his/her practice, university or
46 hospital (collectively referred to as "Employer") when they reduce their work schedule to fulfill
47 their responsibilities as President, President-Elect or Immediate Past President. While this has
48 occurred infrequently, the Committee wanted our AMA to be prepared going forward. In
49 researching possible solutions, the Committee's objective was to arrive at a solution that was
50 fiscally responsible to the AMA, require the President to have some responsibility for the premium

1 cost and provide flexibility to address each President's health insurance needs based on his/her
2 family demographics. An annual stipend to assist the President(s) seemed to meet this goal.

3
4 To determine the amount of the stipend, premiums were obtained from the Health Insurance
5 Marketplace ("Exchange") established under the Patient Protection and Affordable Care Act of
6 2010 to obtain the specific amounts of 2018 premiums. The Committee reviewed the Plan designs
7 offered on the Exchange and determined that the Gold Plan would be the basis for the stipend. The
8 Gold Plan's actuarial value is that the plan covers 80% of expenses. Gold Plan design can vary by
9 state but the actuarial equivalent of the design must be to cover 80% of expenses. In addition,
10 insurance carriers, plan availability, premium amounts and the scope of the network varies state to
11 state down to county level within a state. Premiums are individually determined based on the home
12 zip code of the family and the demographics of each covered family member.

13
14 Demographics of the full Board were used to obtain a broader cross-section of Gold Plan premiums
15 across the country. Board members who qualify for Medicare were excluded from the analysis and
16 would not be eligible for a stipend. With the assistance of AMA's external employee benefits
17 broker, premiums were anonymously obtained based on each Board member's state of residence,
18 and demographics.

19
20 The range of the premiums was significant which demonstrated the need for a "customized"
21 stipend. The Committee determined that the stipend would reflect a "cost-sharing" of the premium
22 for the President and covered family members. Premiums would also change annually. Medicare-
23 eligible President(s) would not be eligible to receive a stipend.

24
25 President(s) who lose his/her employer insurance would substantiate his/her eligibility for an
26 annual stipend by written notice to the Board Chair detailing the effective date of the loss and
27 listing covered family members. The amount of the stipend will be reported as taxable income for
28 the President each calendar year and will be included in this Committee's annual report to the
29 House, which documents compensation paid to Officers and the IRS reported taxable value of
30 benefits, perquisites, services and in-kind payments.

31 32 FINDINGS

33
34 The Committee notes that the President-Elect, President and Immediate Past President
35 responsibilities require a significant time commitment in supporting our AMA in governance and
36 representation functions. Our A-18 report noted that this level of responsibility results in a time
37 commitment well above that required by other not-for-profit boards. The level of commitment
38 needed in supporting our AMA may necessitate a President reduce his/her work schedule with
39 his/her employer to a part-time status which may result in a President losing his/her eligibility for
40 employer's health insurance coverage.

41
42 This Committee considers health insurance a necessity. As such, this Committee recommends that
43 Presidents who are not Medicare-eligible receive a stipend based on 70% of the then current Gold
44 Plan premium for the President and his/her covered family members once the President provides
45 written notice to the Board Chair about the loss of coverage. The stipend would be reported as
46 taxable income to the President(s).

RECOMMENDATIONS

The Committee on Compensation of the Officers recommends the following recommendations be adopted and the remainder of this report be filed:

1. That there be no change to the current Definitions effective July 1, 2018 as they appear in the Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per Diem for External Representation and Telephonic Per Diem for External Representation.

2. Annual Health Insurance Stipend (Stipend)

The purpose of this payment is to provide a Health Insurance Stipend (Stipend) to compensate the President, President-Elect and Immediate Past President under age 65, when the President(s) loses his/her employer-provided medical insurance coverage during his/her term. President(s) who lose his/her employer insurance will substantiate his/her eligibility for the Stipend by written notice to the Board Chair detailing the effective date of the loss of coverage and listing covered family members. The President receiving the Stipend will have the sole discretion to determine the appropriate health insurance coverage for the himself/herself and the family, and provide proof of purchasing such coverage to the Board Chair.

The amount of the Stipend will be 70% of the then current Gold Plan premium in the President(s) state/county of residence for each covered family member. If there are multiple Gold Plans in the state/county, the Stipend will be based on the average of the then current Gold Plan premiums. The amount of the Stipend will be updated January 1 of each Plan year based on then Gold Plan premiums and covered family members. Should a President reach age 65 during his/her term(s), the Stipend will end the month Medicare coverage begins. In all cases the Stipend will end the sooner the President(s) obtains other health insurance coverage, reaches age 65 or the month following the end of his/her term as Immediate Past President. The Stipend will be paid monthly. The amount of the Stipend will be reported as taxable income for the President each calendar year and will be included in this Committee's annual report to the House which documents compensation paid to Officers and the IRS reported taxable value of benefits, perquisites, services and in-kind payments.

3. Except as noted above, there will be no other changes to the Officers' compensation for the period beginning January 1, 2019. (Directive to Take Action)

Fiscal Note: The maximum annual stipend is estimated at \$87,000. This is based on 70% of the highest 2018 Gold Plan Premium based on current Board demographics and assumes all three Presidents and spouses/partners would receive the stipend in the same year.

APPENDIX

POSITION	GOVERNANCE HONORARIUM
President	\$290,160
Immediate Past President & President-Elect	\$284,960
Chair	\$284,960
Chair-Elect	\$280,280
Other Officers	\$207,480

Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation day.

Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is \$1,300 per day.

Definition of Telephonic Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for these meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem or \$650.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(I-18)

Introduced by: Minority Affairs Section

Subject: Support of AAIP's "Desired Qualifications for Indian Health Service Director"

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, The Indian Health Service is a federal agency with a multi-billion dollar budget that provides health care to American Indian and Alaska Native members of federally recognized Tribes; and

Whereas, The basis of this health care provision is a special government-to-government relationship established in 1787, by Article 1, Section 8 of the United States Constitution; and

Whereas, The director of the Indian Health Service is a political appointment that requires confirmation by the United States Senate; and

Whereas, In consideration of the unique demands for the Indian Health Service Director, the Association of American Indian Physicians adopted "Desired Qualifications for the Director of the Indian Health Service"¹, as follows:

1. Health profession, preferably an MD or DO, degree and at least five years of clinical experience.
2. Demonstrated long-term interest, commitment, and activity within the field of Indian Health.
3. Lived on tribal lands or rural American Indian or Alaska Native community or has interacted closely with an urban Indian community.
4. Leadership position in American Indian/Alaska Native health care or a leadership position in an academic setting with activity in American Indian/ Alaska Native health care.
5. Experience in the Indian Health Service or has worked extensively with Indian Health Service, Tribal, or Urban Indian health programs.
6. Knowledge and understanding of social and cultural issues affecting the health of American Indian and Alaska Native people.
7. Knowledge of health disparities among Native Americans / Alaska Natives, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities.
8. Experience working with Indian Tribes and Nations and an understanding of the Trust Responsibility of the Federal Government for American Indian and Alaska Natives as well as an understanding of the sovereignty of American Indian and Alaska Native Nations.
9. Experience with management, budget, and federal programs; therefore be it

¹ AAIP "Desired Qualifications for the Director of the Indian Health Service"
<http://files.constantcontact.com/82ca0b6a001/17d8e3c8-755a-4644-8814-bb60ce9c667c.pdf?ver=1512063577000>

- 1 RESOLVED, That our American Medical Association support the "Desired Qualifications for the
- 2 Director of the Indian Health Service" set forth by the Association of American Indian
- 3 Physicians. (New HOD Policy)

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

Received: 10/03/18

RELEVANT AMA POLICY

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12;

Reaffirmed: Res. 233, A-13)

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Reference Committee J

BOT Report(s)

09 Hospital Closures and Physician Credentialing

CMS Report(s)

01 Prescription Drug Importation for Personal Use

02 Air Ambulance Regulations and Payments

03* Sustain Patient-Centered Medical Home Practices

04 The Site-of-Service Differential

Joint Report(s)

CMS-CSAPH 01* Aligning Clinical and Financial Incentives for High-Value Care

Resolution(s)

801 Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle

802 Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk)

803 Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of "Dense Breasts" on Mammogram

804 Arbitrary Documentation Requirements for Outpatient Services

805 Prompt Pay

806* Telemedicine Models and Access to Care in Post-Acute and Long-Term Care

807* Emergency Department Copayments for Medicaid Beneficiaries

808* The Improper Use of Beers or Similar Criteria and Third-Party Payer Compliance Activities (H-185.940)

809* Medicaid Clinical Trials Coverage

810* Medicare Advantage Step Therapy

811* Infertility Benefits for Active-Duty Military Personnel

812* ICD Code for Patient Harm from Payer Interference

813* Direct Primary Care Health Savings Account Clarification

814* Prior Authorization Relief in Medicare Advantage Plans

815* Uncompensated Physician Labor

816* Medicare Advantage Plan Inadequacies

817* Increase Reimbursement for Psychiatric Services

818* Drug Pricing Transparency

819* Medicare Reimbursement Formula for Oncologists Administering Drugs

820* Ensuring Quality Health Care for Our Veterans

821* Direct Primary Care and Concierge Medicine Based Practices

* contained in the Handbook Addendum

REPORT OF THE BOARD OF TRUSTEES

B of T Report 9-I-18

Subject: Hospital Closures and Physician Credentialing
(Resolution 716-A-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates (HOD) referred Resolution 716-A-18, “Hospital Closures and Physician Credentialing.” Resolution 716 was sponsored by the Organized Medical Staff Section and asked the AMA to:

work with appropriate stakeholders—such as the AMA Organized Medical Staff Section and National Association Medical Staff Services (NAMSS)—to produce an AMA credentialing repository that would allow hospitals and other organizations that credential physicians to access verified credentialing information for physicians who were on staff at a hospital (or one of its departments) at the time of closure, and report back at the 2018 Interim Meeting.

Testimony largely supported the intent of Resolution 716. However, some members noted that not only would the cost of implementing Resolution 716 be significant, but there are also many unanswered questions about the demand for such a service and how it would work. Other members were concerned as to whether the AMA is the organization best positioned to take up this issue.

DISCUSSION

Resolution 716 suggests that a lack of institutional policies for preserving medical staff credentialing files when a hospital closes can lead to undue delays in future credentialing efforts due to inaccessibility of historical credentialing information. To minimize the potentially devastating impact this shortcoming may have on physicians and other displaced medical staff members, Resolution 716 asks that the AMA create a centralized repository to facilitate the verification of credentialing information as it relates to a physician’s hospital affiliation history.

Existing AMA policy supports the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory surgery facilities, nursing homes and other health care facilities. Policy H-230.956, “Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records” states that, where in accordance with state law and regulations, “[t]he governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility...” and “...make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.” Policy H-230.956 also states that the closing facility “...shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information.”

Notwithstanding this comprehensive policy, a thorough review of existing law reveals few requirements for the retention of physician credentialing records when a hospital closes. While some states require hospitals to implement policies for the preservation of medical staff credentialing files (e.g., Illinois and New York), most states have no specific law or regulations providing for the timely transfer of medical staff credentialing files and proper notification to physicians of the location of those files. As a starting point, the AMA should encourage emulation of appropriate existing laws and regulations by developing model state legislation that supports timely physician access to credentialing files following the closure of a hospital.

Even if closing hospitals were required by law to preserve credentialing files, it remains to be seen where and how this information would be most appropriately stored. Resolution 716 suggests the development of a comprehensive and centralized repository of credentialing files from closed hospitals. States, payors, and other stakeholders are already in the process of developing credentialing repositories for verification of physicians' current and past hospital affiliations. For example, Oregon passed legislation to establish a centralized credentialing database from which medical staff professionals, hospitals, health plans, and other organizations can get up-to-date information on every licensed physician in the state. Additionally, the National Association Medical Staff Services (NAMSS) has launched an online repository to provide medical staff offices a place to quickly find and upload physician affiliation history. Either of these efforts could be expanded to address the problems raised by closed facilities. Recognizing the value that the AMA could provide alongside expert leaders in the credentialing industry, the AMA should continue to monitor these efforts and explore the feasibility of developing a universal clearinghouse that centralizes the verification of physician practice and affiliation history.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 716-A-18 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-230.956, which states that the governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility should be responsible for making arrangements for the disposition of physician credentialing records upon the closing of a facility and should make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, and medical staff status. (Reaffirm HOD Policy)
2. That our AMA develop model state legislation and regulations that would require hospitals to:
 - (a) implement a procedure for preserving medical staff credentialing files in the event of the closure of the hospital; and
 - (b) provide written notification to its state health agency and medical staff before permanently closing its facility indicating whether arrangements have been made for the timely transfer of credentialing files and the exact location of those files. (Directive to Take Action)
3. That our AMA: (a) continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations; and (b) explore the feasibility of developing a universal clearinghouse that centralizes the verification of credentialing information as it relates to physician practice and affiliation history, and report back to the House of Delegates at the 2019 Interim Meeting. (Directive to Take Action)

Fiscal Note: Modest – Between \$1,000 and \$5,000

Relevant AMA Policy

H-230.956, "Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records"

1. AMA policy regarding the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory surgery facilities, nursing homes and other health care facilities, where in accordance with state law and regulations is as follows:
 - A. Governing Body to Make Arrangements: The governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility.
 - B. Transfer to New or Succeeding Custodian: Such a facility shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information. In the alternative, the facility shall seek to make arrangements with a reputable commercial storage firm. The new or succeeding custodian shall be obligated to treat these records as confidential.
 - C. Documentation of Physician Credentials: The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.
 - D. Maintenance and Retention: Physician credentialing information and CME information transferred from a closed facility to another hospital, other entity, or commercial storage firm shall be maintained in a secure manner intended to protect the confidentiality of the records.
 - E. Access and Fees: The new custodian of the records shall provide access at a reasonable cost and in a reasonable manner that maintains the confidential status of the records.
2. Our AMA advocates for the implementation of this policy with the American Hospital Association.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-18

Subject: Prescription Drug Importation for Personal Use
(Resolution 226-I-17)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

At the 2017 Interim Meeting, the House of Delegates referred Resolution 226-I-17, “Prescription Drug Importation for Personal Use,” which was sponsored by the Minnesota delegation. Resolution 226-I-17 asked that our American Medical Association (AMA) support legislation that would allow for the personal purchase and importation of prescription drugs obtained directly from a licensed Canadian pharmacy, provided such drugs are for personal use and of a limited quantity. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2018 Interim Meeting.

This report addresses the in-person purchase and importation of prescription drugs obtained directly from a licensed, “brick-and-mortar” Canadian pharmacy, not the importation of drugs via online or mail-order pharmacies. The Council notes that Policy D-100.983 guides AMA advocacy on these aspects of the prescription drug importation issue, and states that our AMA will:

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

This report provides background on prescription drug pricing and spending in the United States and Canada; summarizes US federal law and regulatory authority addressing prescription drug

importation; highlights activities to ensure US pharmaceutical chain integrity; reviews how prescription drugs and pharmacies are regulated in Canada; outlines relevant legislative and administrative activity; and presents policy recommendations.

BACKGROUND

In 2016, the US had the highest pharmaceutical spending per capita in the world at \$1,443, versus \$613 in Canada. Retail spending on prescription drugs per capita was also highest in the US at \$1,026, with Canada's retail per capita spending amounting to roughly half that of the US. Public spending on prescription drugs accounted for 36 percent of total pharmaceutical spending in Canada, and 34 percent in the US. Private insurance accounted for 36 percent of total pharmaceutical spending in the US and 30 percent in Canada, with private out-of-pocket spending accounting for 34 percent in Canada, and 30 percent in the US.¹

Differential pricing for pharmaceuticals between the US and Canada reflects differences in how pharmaceutical prices are determined in each country. Contributing factors to pharmaceutical pricing include the level of government negotiation authority, price controls mandated by law, and market exclusivity and manipulations. In Canada, the Patented Medicine Prices Review Board, a federal, independent, quasi-judicial body, regulates the prices of patented medications to ensure that they are not excessive. Price increases of existing patented drugs cannot exceed the Consumer Price Index. Of note, the Board only regulates the price at which patented drugs are sold to wholesalers, hospitals, pharmacies and other entities by their respective patent holders, and does not have jurisdiction over wholesale or pharmacy prices. In addition, the Board only has the authority to regulate the prices of patented drugs, not generic drugs. Provinces have the authority over the pricing of generic drugs, as well as the pricing of prescription drugs under public drug plans.^{2,3} In addition, the pan-Canadian Pharmaceutical Alliance, with the participation of provinces, territories and federal drug plans, conducts joint negotiations for the pricing of publicly covered drugs.⁴

When faced with high out-of-pocket costs for prescription drugs, some patients in the US pursue the importation of their medications from other countries, including Canada. In fact, eight percent of respondents in a recent Kaiser Health Tracking Poll indicated that they or someone in their household had imported prescription drugs from Canada or other countries outside of the US.⁵

FEDERAL LAW ADDRESSING PRESCRIPTION DRUG IMPORTATION

Under current US law, based on provisions of the Medicare Modernization Act of 2003 as well as the Medicine Equity and Drug Safety Act of 2000, HHS has the authority to permit importation of prescription drugs from Canada if the HHS Secretary certifies to Congress that they would pose no additional risk to the public's health and safety, and would result in a significant reduction in the cost of the drugs to Americans. However, no HHS Secretary has been willing to provide the enabling certification for prescription drug importation, thus preventing its implementation.⁶ Because prescription drugs from other countries often have not been approved by the FDA for use and sale in the US, it generally remains illegal for individuals to import prescription drugs into the US for personal use. Without FDA approval and enforcement authority, the safety and effectiveness of imported drugs cannot be assured.

Current law, however, also gives the FDA discretion in enforcement of the importation of prescription drugs by individuals, which allows the FDA's "personal-use" or "compassionate-use" policy. Under the policy, the FDA allows the personal importation of prescription drugs under very limited circumstances, described by the agency as:

- 1 • The drug is for use for a serious condition for which effective treatment is not available in
- 2 the US;
- 3 • There is no commercialization or promotion of the drug to US residents;
- 4 • The drug does not represent an unreasonable risk;
- 5 • The individual importing the drug verifies in writing that it is for personal use, and
- 6 provides contact information for the doctor providing treatment or shows the product is for
- 7 the continuation of treatment begun in a foreign country; and
- 8 • Generally, not more than a 3-month supply of the drug is imported.⁷

9

10 The FDA also has utilized its enforcement discretion to allow importation in the case of a shortage

11 of a prescription drug. In the case of such shortages, when manufacturers of an FDA-approved

12 prescription drug cannot resolve a shortage immediately, the FDA sometimes has had to turn to

13 foreign versions of the drug with the same active ingredient manufactured by firms the FDA deems

14 as reputable and reliable. As a result, the limited importation of the foreign version of the drug has

15 been allowed until the shortage is resolved.⁸ Of note, such enforcement discretion has been used

16 sparingly, including for propofol in 2010 and 2012, ethiodol in 2011 and 2015, methotrexate

17 injection and liposomal doxorubicin in 2012 and tretinoin capsules in 2016.⁹

18

19 US PHARMACEUTICAL SUPPLY CHAIN INTEGRITY

20

21 In the US, the FDA has the authority to ensure the integrity of the US pharmaceutical supply chain,

22 from raw materials to manufacturing facilities to use by patients. The FDA is undergoing several

23 initiatives to protect the global prescription drug supply chain, responding to the fact that

24 approximately 40 percent of finished prescription drugs are imported in the US, and 80 percent of

25 active pharmaceutical ingredients come from overseas sources. Such initiatives are targeted at

26 preventing substandard, adulterated and counterfeit drugs from entering the US, and appropriately

27 communicating risks to patients and providers. The FDA completed 4,936 Good Manufacturing

28 Practice inspections of registered drug and device establishments in 2017, and issues annual reports

29 outlining such inspections as well as the percentage of the FDA budget used to fund such

30 inspections. The FDA also has administrative detention authority to prevent the distribution or

31 subsequent use of drugs suspected to be adulterated or misbranded at the time of inspection until

32 the agency determines what action it should take concerning the drugs, including the initiation of

33 legal action.^{10,11} In addition, the FDA is working towards fully implementing the Drug Supply

34 Chain Security Act by 2023. The Act, which was Title II of the Drug Quality and Security Act, was

35 enacted into law in 2013 and outlines steps to build an electronic, interoperable system to identify

36 and trace certain prescription drugs as they are distributed in the US.¹²

37

38 CANADIAN REGULATION OF PRESCRIPTION DRUGS AND PHARMACIES

39

40 Health Canada reviews prescription drugs to assess their safety, effectiveness and quality before

41 they are authorized for sale in Canada, and performs continuous evaluations after such drugs are on

42 the market, including monitoring adverse reactions. Once approved for sale, prescription drugs in

43 Canada are issued an eight-digit Drug Identification number, which indicates that Health Canada

44 considers the drug safe and effective, and provides a mechanism to track adverse reactions. Also,

45 Health Canada licenses and conducts inspections of pharmaceutical manufacturers, importers and

46 distributors. In order to prevent unauthorized drug products from entering Canada, including

47 counterfeit and adulterated drugs, Health Canada works in cooperation and coordination with the

48 Canada Border Services Agency.^{13,14} The FDA has voiced its confidence in Health Canada in

49 providing effective oversight of drugs approved for use by Canadian patients.¹⁵

1 There are 10,947 licensed pharmacies in Canada, including 10,463 community pharmacies.¹⁶
2 Provincial and territorial pharmacy regulatory authorities regulate the practice of pharmacy and the
3 operation of pharmacies in their respective jurisdictions in Canada. This includes the licensing of
4 pharmacies in Canada, including traditional “brick-and-mortar” pharmacies and storefront
5 pharmacies that conduct business online.¹⁷
6

7 RELEVANT ADMINISTRATIVE AND LEGISLATIVE ACTIVITY

8

9 In response to the request of HHS Secretary Alex Azar in July 2018, a work group will assess how
10 to safely import prescription drugs from other countries under certain narrow circumstances not
11 involving a shortage, namely in the event of a significant price increase for a prescription drug that
12 is only produced by one manufacturer and not protected by patents or exclusivities. The FDA
13 Commissioner has stressed that if drugs that fall under this categorization can be imported in a
14 manner that ensures safety and effectiveness, such importation would be temporary until there is
15 sufficient competition.^{18,19}
16

17 In addition, legislation has been introduced to permit prescription drug importation. Legislative
18 approaches to prescription drug importation vary in many respects. For example, while some bills
19 focus on the importation of prescription drugs from Canada, therefore requiring the Secretary of
20 HHS to promulgate the necessary regulations on this issue, other bills could potentially allow
21 prescription drug importation from additional countries that meet standards for ensuring the safety
22 and effectiveness of drugs that are at least as protective as such standards in the US. Bills also vary
23 in defining the foreign pharmacies and entities from which individuals can import prescription
24 drugs.
25

26 Senator John McCain (R-AZ) and Congresswoman Chellie Pingree (D-ME) have introduced
27 S 64/HR 1480, the Safe and Affordable Drugs from Canada Act of 2017. S 64/HR 1480, if enacted
28 into law, would compel the HHS Secretary to promulgate regulations within 180 days permitting
29 individuals to import a prescription drug purchased from an approved Canadian pharmacy that: is
30 dispensed by a pharmacist licensed in Canada; is purchased for personal use in quantities not
31 greater than a 90-day supply; is filled using a valid prescription issued by a physician licensed to
32 practice in the US; and has the same active ingredients, route of administration, dosage form, and
33 strength as a prescription drug approved under the Federal Food, Drug, and Cosmetic Act. The
34 legislation does not authorize importation of certain medications, including controlled substances
35 and biological products. The bill establishes a certification process for approving Canadian
36 pharmacies and HHS would have to publish a list of approved Canadian pharmacies.^{20,21} Senator
37 McCain also introduced S 92, legislation with the same title and most of the same text as S 64, but
38 differing in that it would give HHS 185 days to promulgate regulations permitting individuals to
39 import a prescription drug purchased from an approved Canadian pharmacy instead of 180 days.²²
40

41 Congressman Keith Ellison (D-MN) has introduced HR 934, the Personal Drug Importation
42 Fairness Act of 2017. If enacted into law, the legislation would allow a drug to be imported by a
43 person other than the drug’s manufacturer if the drug has the same active ingredients, route of
44 administration, and strength as an approved drug. The bill also states that drugs could be imported
45 or reimported from the following countries if the FDA determines that they have standards for
46 ensuring drug safety and effectiveness that are at least as protective as US standards: Australia,
47 Canada, Israel, Japan, New Zealand, Switzerland, South Africa, a member-state of the European
48 Union, or a country in the European Economic Area. Prescription drugs to be imported would be
49 required to be dispensed by a licensed pharmacist; be shipped directly to, or imported by, the
50 ultimate consumer; and shipped or imported in quantities that do not exceed a 90-day supply. The
51 bill would prohibit the importation of controlled substances.²³

1 Senator Bernie Sanders (I-VT) and Congressman Elijah Cummings (D-MD) have introduced
2 S 469/HR 1245, the Affordable and Safe Prescription Drug Importation Act. If enacted into law,
3 the legislation would require HHS to issue regulations within 180 days allowing wholesalers,
4 licensed US pharmacies, and individuals to import qualifying prescription drugs manufactured at
5 FDA-inspected facilities from licensed Canadian sellers. After two years, the Secretary would have
6 the authority to permit importation from countries in the Organisation for Economic Co-operation
7 and Development that meet specified statutory or regulatory standards that are comparable to US
8 standards. The bill would prohibit the importation of controlled substances, anesthetic drugs
9 inhaled during surgery, and compounded drugs. The bill stipulates that an individual may import a
10 qualifying prescription drug for personal use in quantities not greater than a 90-day supply from an
11 online pharmacy or by a certified foreign seller that is a licensed foreign pharmacy. The bill also
12 would require that individuals importing qualifying prescription drugs must provide to the licensed
13 foreign pharmacy a valid prescription issued by a health care practitioner licensed to practice in the
14 US.^{24,25}

15
16 There also has been state activity in the arena of prescription drug importation. Nine states have
17 introduced drug importation legislation this year, with Vermont enacting a law that would allow
18 drug importation from Canada through authorized wholesalers.²⁶ The state is required to submit a
19 drug importation proposal for federal approval.²⁷ Without federal approval, Vermont's law will
20 face the same fate as Maine's, which was enacted in 2013 to allow its citizens to import
21 prescription drugs from Canada, New Zealand, Australia, and the United Kingdom. However, in
22 2015, a federal district court ruled that Maine's law was unconstitutional, as federal law preempts
23 state law on this issue.²⁸

24 25 DISCUSSION

26
27 Supporting the ability of US patients to purchase and import prescription drugs in-person from a
28 licensed Canadian pharmacy has the potential to improve patient cost-sharing levels if significant
29 cost savings could be achieved, which would positively address one barrier to medication
30 adherence. The Council notes that under such a policy, some patient medications, including
31 controlled substances and biologicals, may not be allowed to be imported. Nevertheless, the
32 Council believes that a risk to patients who pursue the importation of prescription drugs from
33 Canada remains, especially those who import such drugs via the Internet which increases the risk
34 of receiving substandard, adulterated and counterfeit drugs.

35
36 Policy D-100.983 provides a strong, balanced approach to guide the support of our AMA for the
37 legalized importation of prescription drug products by wholesalers and pharmacies, as well as the
38 personal importation of prescription drugs via the Internet. Critically, the policy predicates AMA
39 support for prescription drug importation on ensuring that safety concerns with imported
40 prescription drugs are addressed, to ensure that they are of the same quality and chemical makeup
41 as those currently distributed in the US. While in-person importation from licensed pharmacies in
42 Canada may face fewer safety concerns than importing prescription drugs via the Internet which
43 would then be shipped to patients, ensuring the safety of such imported drugs must remain a
44 priority. Therefore, the Council recommends that our AMA support the in-person purchase and
45 importation of prescription drugs obtained directly from a licensed Canadian pharmacy when
46 product integrity can be assured, provided such drugs are for personal use and of a limited quantity.
47 The Council also believes that the FDA needs new and additional resources to administer and
48 enforce a program that allows the in-person purchase and importation of prescription drugs from
49 Canada, if the safety of in-person importation can be assured.

Also addressing the critical issue of safety of imported prescription drugs, the Council recommends the reaffirmation of Policy D-100.985, which states that our AMA will continue to actively oppose illegal drug diversion, illegal Internet sales of drugs, illegal importation of drugs, and drug counterfeiting. In addition, the policy calls for our AMA to work with the Congress, the FDA, the Drug Enforcement Administration, and other federal agencies, the pharmaceutical industry, and other stakeholders to ensure that these illegal activities are minimized.

Allowing for the in-person importation of prescription drugs from licensed Canadian pharmacies is not a comprehensive, long-term solution to addressing the problem of unaffordability of prescription drugs in the US. The Council believes that sustainable solutions to addressing high and unaffordable prescription drug prices can be found by addressing the flaws and inefficiencies in the US pharmaceutical marketplace. However, patients that face high and unaffordable costs for their prescription drugs need relief in the meantime. Your Council believes that supporting the in-person purchase and importation of prescription drugs from Canada, if the safety of importation can be assured, represents a measured and conservative option to lower patient costs for prescription drugs.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 226-I-17, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support the in-person purchase and importation of prescription drugs obtained directly from a licensed Canadian pharmacy when product integrity can be assured, provided such drugs are for personal use and of a limited quantity. (New HOD Policy)
2. That our AMA advocate for an increase in funding for the US Food and Drug Administration to administer and enforce a program that allows the in-person purchase and importation of prescription drugs from Canada, if the integrity of prescription drug products imported for personal use can be assured. (New HOD Policy)
3. That our AMA reaffirm Policy D-100.983, which outlines criteria for supporting the legalized importation of prescription drug products by wholesalers and pharmacies, and opposes the personal importation of prescription drugs via the Internet until patient safety can be assured. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy D-100.985, which opposes the illegal importation of prescription drugs and drug counterfeiting, and supports working with Congress, federal agencies and other stakeholders to ensure that these illegal activities are minimized. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500

REFERENCES

- ¹ Papanicolas I, Woskie LR, Jha AK. Health care spending in the United States and other high-income countries. JAMA. 2018; 319(10):1024-1039.
- ² Allin, S and Rudoler, D. The Canadian Health Care System. International Health Care System Profiles. The Commonwealth Fund. Available at: <http://international.commonwealthfund.org/countries/canada/>.
- ³ Patented Medicine Prices Review Board. Frequently Asked Questions. Available at: <http://www.pmprb-cepmb.gc.ca/about-us/frequently-asked-questions>.
- ⁴ The pan-Canadian Pharmaceutical Alliance. The Council of the Federation: Canada's Premiers. Available at <http://www.canadaspremiers.ca/pan-canadian-pharmaceutical-alliance/>.
- ⁵ Kaiser Family Foundation. Kaiser Health Tracking Poll. November 2016. Available at: <http://files.kff.org/attachment/Kaiser-Health-Tracking-Poll-November-2016-Topline>.
- ⁶ The Pew Charitable Trusts. Policy Proposal: Importation of Prescription Drugs. Available at: <http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2017/04/policy-proposal-importation-of-prescription-drugs>.
- ⁷ US Food and Drug Administration. Personal Importation. Available at: <https://www.fda.gov/ForIndustry/ImportProgram/ImportBasics/ucm432661.htm>.
- ⁸ US Food and Drug Administration. FDA Works to Lessen Drug Shortage Impact. Available at: <https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm258152.htm>.
- ⁹ US Food and Drug Administration. PowerPoint presentation of Captain Valerie Jensen, RPh: Preventing and Mitigating Drug Shortages – FDA's and Manufacturers' Roles. Available at: <https://www.fda.gov/downloads/drugs/newsevents/ucm493617.pdf>.
- ¹⁰ US Food and Drug Administration. Food and Drug Administration Safety and Innovation Act (FDASIA). Available at: <https://www.fda.gov/RegulatoryInformation/LawsEnforcedbyFDA/SignificantAmendmentstotheFDCA/FDASIA/ucm20027187.htm>.
- ¹¹ US Food and Drug Administration. CY 2017 Annual Report on Inspections of Establishments. Available at: <https://www.fda.gov/downloads/RegulatoryInformation/LawsEnforcedbyFDA/SignificantAmendmentstotheFDCA/FDASIA/UCM611383.pdf>.
- ¹² US Food and Drug Administration. Drug Supply Chain Security Act (DSCSA). Available at: <https://www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/DrugSupplyChainSecurityAct/default.htm>.
- ¹³ Government of Canada. How drugs are reviewed in Canada. Available at: <https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/fact-sheets/drugs-reviewed-canada.html>.
- ¹⁴ Government of Canada. Buying drugs over the Internet. Available at: <https://www.canada.ca/en/health-canada/services/buying-drugs-over-internet.html>.
- ¹⁵ Ashley, D. Correspondence: The Price of Crossing the Border for Medications. N Engl J Med. 2017; 377(17):1699.
- ¹⁶ National Association of Pharmacy Regulatory Authorities. National Statistics. Available at: <http://napra.ca/national-statistics>.
- ¹⁷ National Association of Pharmacy Regulatory Authorities. Pharmacy Regulation in Canada. Available at: <http://napra.ca/pharmacy-regulation-canada>.
- ¹⁸ Best, D. Report on 100 Days of Action on the American Patient First Blueprint. US Department of Health and Human Services. August 2018. Available at: https://www.hhs.gov/sites/default/files/ReportOn100DaysofAction_AmericanPatientsFirstBlueprint.pdf.
- ¹⁹ US Food & Drug Administration. Statement by FDA Commissioner Scott Gottlieb, M.D., on the formation of a new work group to develop focused drug importation policy options to address access challenges related to certain sole-source medicines with limited patient availability, but no blocking patents or exclusivities. July 19, 2018. Available at: <https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm613931.htm>.
- ²⁰ S 64, the Safe and Affordable Drugs from Canada Act of 2017. Available at: <https://www.congress.gov/115/bills/s64/BILLS-115s64is.pdf>.
- ²¹ HR 1480, the Safe and Affordable Drugs from Canada Act of 2017. Available at: <https://www.congress.gov/115/bills/hr1480/BILLS-115hr1480ih.pdf>.

²² S 92, the Safe and Affordable Drugs from Canada Act of 2017. Available at: <https://www.congress.gov/115/bills/s92/BILLS-115s92is.pdf>.

²³ HR 934, the Personal Drug Importation Fairness Act of 2017. Available at: <https://www.congress.gov/115/bills/hr934/BILLS-115hr934ih.pdf>.

²⁴ S 469, the Affordable and Safe Prescription Drug Importation Act. Available at: <https://www.congress.gov/115/bills/s469/BILLS-115s469is.pdf>.

²⁵ HR 1245, the Affordable and Safe Prescription Drug Importation Act. Available at: <https://www.congress.gov/115/bills/hr1245/BILLS-115hr1245ih.pdf>.

²⁶ National Academy for State Health Policy. State Legislative Action to Lower Pharmaceutical Costs. Updated June 22, 2018. Available at: <https://nashp.org/state-legislative-action-on-pharmaceutical-prices/>.

²⁷ National Academy for State Health Policy. How Vermont Will Implement Its Groundbreaking Rx Drug Importation Law. Available at: <https://nashp.org/how-vermont-will-implement-its-groundbreaking-drug-importation-law/>.

²⁸ Silverman, E. Judge Strikes Down Maine Law for Importing Prescription Medicines. The Wall Street Journal. February 25, 2015. Available at: <https://blogs.wsj.com/pharmalot/2015/02/25/judge-strikes-down-maine-law-for-importing-prescription-medicines/>.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-18

Subject: Air Ambulance Regulations and Payments

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

At the American Medical Association's (AMA) 2017 Interim Meeting, the House of Delegates adopted policy D-130.964, "Air Ambulance Regulations and Reimbursements," which directs the AMA and appropriate stakeholders to study the role, clinical efficacy, and cost-effectiveness of air ambulance services, including barriers to adequate competition, reimbursement, and quality improvement.

This report provides background on air ambulances including an outline of the various air ambulance business models in the market, discusses the costs and insurance coverage of air ambulance services, summarizes relevant AMA policy, provides an overview of legislative activity on air ambulances, and suggests policy recommendations.

BACKGROUND

Helicopters provide emergency scene responses and interfacility transfers while fixed-wing aircraft provide longer distance airport-to-airport transports. For the purposes of this report, the Council focuses on helicopter air ambulances, which account for about 74 percent of all air ambulances and most of the research on air ambulances.¹ Furthermore, Policy D-130.964 directs the report's scope to focus on the role, clinical efficacy, and cost for air ambulance services.

Air ambulances are used to expeditiously transport critically ill patients during life-threatening emergencies. Air ambulances are equipped with medical equipment and staffed by medical professionals similar to traditional ground ambulances. Air ambulances are widely considered to have a beneficial impact on improving the chances of survival and recovery for both trauma victims and other patients in critical condition. In some rural areas that lack advanced-care facilities like trauma centers, air ambulances fill a critical gap and provide patients timely access to the treatment they need.²

Air ambulances allow for optimization of patient care and outcomes. In emergency medicine, the "golden hour" refers to a time period lasting for about one hour following traumatic injury or medical emergency during which there is the highest probability that rapid medical treatment will prevent further deterioration or death. Air ambulances increase the likelihood of patients receiving needed care within the "golden hour" because of their ability to land at accident sites and quickly fly to nearby hospitals therefore reducing transport times. Unlike other aviation and medical services, air ambulance transfers take place in response to time-sensitive medical emergencies and generally are not scheduled ahead of time.³ Patients often have little to no ability to make cost-saving decisions before the transport, such as ensuring that the air ambulance provider participates in the patient's insurance plan.

1 It is estimated that more than 550,000 patients in the US use air ambulance services every year.
2 Further, air ambulance services have increased significantly in recent years. In 2002, there were
3 about 400 air ambulances in use across the US, and that number more than doubled to over 800 air
4 ambulances by 2008.⁴ This increase in the number of air ambulances has sparked criticism from
5 consumer groups of oversupply and contributing to the overuse of air ambulance services that may
6 not be medically necessary. It is estimated that nearly a third of patients transported via air
7 ambulance helicopter were minimally injured.⁵ In addition to possible unnecessary use of air
8 ambulances, other reasons for the growth in the industry include an aging population, a decrease in
9 the number of emergency departments in hospitals, and changes in health care delivery in rural
10 settings.

11
12 Air ambulances have emerged as one solution to the problem of rural health care facility closures.
13 A quarter of Americans, or 85 million people, are estimated to be unable to access health care in
14 less than an hour of travel time without an air ambulance, and such ambulances may be the only
15 viable means of transporting patients to the care center they need.⁶ However, over the past decade,
16 many states have reported issues with air ambulance providers who are not affiliated with any
17 hospital or insurance carrier.

18 19 AIR AMBULANCE BUSINESS MODEL

20
21 Air ambulance providers generally function in one of three business models based on the entity that
22 owns the air ambulance and the individuals providing medical services aboard the aircraft. The first
23 model is a hospital-based model wherein the hospital provides medical services and staff and
24 typically contracts with third parties for the pilots, aircraft, and maintenance. The second model is
25 the independent model wherein operations are not controlled by a specific medical facility.
26 Independent models may consist of for-profit or non-profit providers who directly employ the
27 medical and flight crews to provide services. The third model is the government model where a
28 state, municipal government, or military unit owns and operates the air ambulances.⁷

29
30 Until 2002, air ambulances were primarily owned and operated by hospitals. However, in 2002,
31 Medicare created a national fee schedule for air ambulances based on a thorough investigation into
32 the “reasonable cost” for emergency medical services (EMS). The national fee schedule had the
33 effect of increasing the Medicare reimbursement rate for helicopter air ambulance transport and in
34 particular raising the rate of payment for rural air transports.⁸

35
36 Due in part to the establishment of the fee schedule, for-profit companies established and expanded
37 their air ambulance businesses. Currently, it is estimated that more than half of the air ambulance
38 industry is controlled by four for-profit air ambulance operators. The doubling of the number of air
39 ambulances since 2002 potentially may be attributed to the closure of clinics and hospitals in rural
40 areas.

41 42 COST AND COVERAGE OF SERVICES

43
44 Patients typically have little to no choice over the service or provider of an air ambulance due to the
45 urgent nature of the transports. Furthermore, air ambulance providers generally do not turn away
46 patients based on their ability to pay and garner payments from patients’ insurance companies. Air
47 ambulance providers typically charge standard rates based on an established lift-off fee and per
48 mile fee for all transports and receive payments from various sources at differing rates depending
49 on a patient’s insurance coverage. Further, the amount paid by private health insurance hinges on
50 whether the air ambulance provider participates in a contract with the private insurer.

1 Depending on insurance coverage, patients can be billed for air ambulance charges that have
2 potentially significant financial consequences. Costs for the average air ambulance trip run in the
3 tens of thousands of dollars. According to the Centers for Medicare & Medicaid Services (CMS)
4 and private health insurance data, between 2010 and 2014, the median prices providers charged for
5 air ambulance service doubled from about \$15,000 to about \$30,000 per transport.⁹ According to
6 numerous air ambulance providers, privately insured patients account for the largest percentage of
7 their revenue. The median payment that three large national private insurers paid per air ambulance
8 transport increased from about \$15,600 to \$26,600 from 2010 to 2014, an increase of 70 percent.
9 With insurers under pressure to cut costs, they have been reducing payments for air ambulances.¹⁰

10
11 Although air ambulances account for less than one percent of total ambulance claims, they
12 represent about eight percent of Medicare spending on ambulance services due to their significant
13 cost. Air ambulance providers are not permitted to balance bill Medicare and Medicaid patients
14 beyond deductibles and coinsurance requirements. Patients with private insurance may be balance
15 billed only if the air ambulance provider is out-of-network. Patients without insurance may be
16 billed for the total price of the air ambulance bill. Due to a lack of information, it is unclear to what
17 extent air ambulance providers balance bill.

18
19 Numerous factors likely contribute to the high costs of air ambulance services, including the price
20 and maintenance of the necessary equipment and employment of specialized medical personnel
21 around-the-clock. In order to stay in operation, air ambulance providers must earn revenue
22 sufficient to cover their costs. The median cost per base for independent air programs is almost
23 \$3 million, with 77 percent of the costs incurred being fixed costs associated with operating a
24 base.¹¹ To increase revenue, air ambulance providers need to increase the number of transports or
25 the cost charged per transport. According to eight air ambulance providers, the average cost they
26 incurred per transport is between \$6,000 to \$13,000.¹²

27
28 A more thorough look into the factors affecting air ambulance pricing is not possible due to lack of
29 data. For example, the cost incurred by air ambulance providers to provide service is not readily
30 available, and there is no national database with this information. Moreover, there are no data
31 available that address cost differences of air ambulance service capabilities and how cost is affected
32 not only by transport but also service level. In addition, available data are insufficient to discern the
33 prices charged by air ambulances, charges across various air ambulance business models, and
34 charges to individuals with varying coverage statuses. The lack of systematic data collection makes
35 it impossible to determine the market share of particular air ambulance providers and corresponding
36 price information.

37 38 LEGISLATIVE ACTIVITY

39
40 Though some states have attempted to create consumer protections from costly air ambulance bills,
41 federal preemption has largely prevented state regulation. The Airline Deregulation Act (ADA) of
42 1978 prohibits states from regulating the price, route, or service of an air carrier for the purposes of
43 keeping national commercial air travel competitive.¹³ The ADA applies to air carriers that provide
44 air ambulance services and are, therefore, protected from state attempts to regulate their price,
45 route, and service. Accordingly, air ambulance providers generally are not subject to the price
46 competition that usually occurs in competitive markets wherein high prices will lead consumers to
47 find lower-cost alternatives.

In contrast to air ambulances, ground ambulances are regulated under the Affordable Care Act (ACA) and applicable state laws.¹⁴ However, for air ambulances, such protections are applied only with the model in which the ambulance service is affiliated with the hospital and, therefore, considered an extension of the emergency department service.

Numerous states have attempted to pass legislation to protect consumers from out-of-network air ambulance bills; however, these laws have been preempted by the ADA.¹⁵ Federal legislation is necessary in order to give states the authority to address the issue. Generally, state insurance regulators support legislation allowing states the flexibility to protect consumers from excessive out-of-network charges. Regulators have shown a willingness to regulate how air ambulance carriers are paid, participate in networks, balance bill, and make information transparent to consumers.

RELEVANT AMA POLICY

Policy H-285.904 includes principles related to unanticipated out-of-network care and states that patients must not be financially penalized for receiving unanticipated care from an out-of-network provider, insurers must meet appropriate network adequacy standards, and patients seeking emergency care should be protected under the “prudent layperson” legal standard. Similarly, Policy D-130.975 advocates that insurers pay for EMTALA services regardless of in-network and out-of-network status.

Policy D-130.989 states that legislation and regulation should be used to require all health payers to cover emergency services. Policy H-130.970 promulgates principles on access to emergency services and states that all physician and health care facilities have an ethical and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. Importantly, the policy notes that health plans should educate enrollees regarding the appropriate use of emergency facilities. Similarly, Policy H-130.954 supports the education of physicians and the public about the costs of inappropriate use of emergency patient transportation systems and encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care. Moreover, Policy H-130.970 states that all health plans should be required to cover emergency services provided by physicians and hospitals to plan enrollees without regard to prior authorization or the emergency care physician’s contractual relationship with the payer. The policy also encourages states to enact legislation holding health plans and third-party payers liable for patient harm resulting from any restrictions on the provision of emergency services. Policy D-130.975 similarly states that all insurers should be required to assign payments directly to any health care provider who has provided EMTALA-mandated emergency care, regardless of network status.

Policy H-240.978 supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term “appropriate facility” to allow full payment for transport to the most appropriate facility based on the patient’s needs and the determination made by physician medical direction. The policy goes on to state that the AMA will work with CMS to pay emergency medical service providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS defined transport locations.

To promote the safety of emergency medical service helicopters, Policy D-130.967 highlights the importance of the Federal Aviation Administration’s Helicopter Medical Service Operations and Safety Alert for Operators and its role as a critical component of Helicopter Emergency Medical Services in assuring the safety of patients and medical providers. The policy goes on to advocate that its members contract with or implement a Helicopter Emergency Medical Service that is

compliant with risk reduction systems/programs established in standards set forth in the Federal Aviation Administration's Helicopter Medical Service Operations and Safety Alert for Operators.

DISCUSSION

Air ambulances serve to reduce the transit time for critically ill patients in emergent circumstances. Due to the nature of air ambulance services, patients typically have little or no choice over their mode of transportation and the provider of such transportation and can face significant air ambulance bills.

To address the appropriate provision of emergency care and consistent with ethical delivery of care, the Council recommends amending Policy H-130.954 not only to support the education of physicians and the public, but also first responders, about the costs associated with inappropriate use of emergency patient transportation systems and encouraging the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

Many aspects of the air ambulance market and the extent patients are balance-billed are unclear due to lack of available data. There is a void in data on ownership, revenue, and service capabilities. Similarly, data on the costs to provide service, the number of transports, and provider information are not readily available. For example, it is unclear whether price increases are tied to market concentration or whether providers adjust prices to receive sufficient revenue from private insurance to account for lower-paid transports, such as those paid for by Medicare. Moreover, there is evidence that in markets with predominantly hospital-owned air ambulance providers, patients are balance-billed at lower rates and face lower costs. However, because these data cannot be verified at this time, the Council believes it is most appropriate to support increased data collection and data transparency of air ambulance providers and services, particularly increased price transparency. Subsequently, the Council recommends supporting consumer disclosures that include price variation among air ambulance providers and the potential limits of insurance coverage.

As previously discussed, the ADA preempts state-level regulation of air ambulance prices, routes, and services. Due to a profound void in air ambulance data, the Council believes that calling for an amendment to the ADA is premature. Before such a recommendation could even be considered, the Council believes that requisite information is needed on air ambulance command and control practices as well as additional data to determine the root cause of the issue at hand, and whether it is a result of market failure or other causes. Therefore, the Council strongly calls for additional data collection and transparency on air ambulances and sees merit in working with relevant stakeholders to evaluate the ADA as it applies to air ambulances.

The AMA believes that access to affordable emergent health care services must be preserved and strengthened. In that spirit, the Council recommends supporting the sharing of industry best practices among stakeholders across various regions. The Council's recommendations build upon the AMA's work to improve safe and affordable air ambulance access and protect patients in life-threatening emergencies.

RECOMMENDATIONS

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

- 1 1. That our American Medical Association (AMA) amend Policy H-130.954, “Non-
2 Emergency Patient Transportation Systems,” by addition as follows:
3 The AMA: (1) supports the education of physicians, first responders, and the public about
4 the costs associated with inappropriate use of emergency patient transportation systems;
5 and (2) encourages the development of non-emergency patient transportation systems that
6 are affordable to the patient, thereby ensuring cost effective and accessible health care for
7 all patients. (Modify Current HOD Policy)
8
- 9 2. That our AMA support increased data collection and data transparency of air ambulance
10 providers and services to the appropriate state and federal agencies, particularly increased
11 price transparency. (New HOD Policy)
12
- 13 3. That our AMA work with relevant stakeholders to evaluate the Airline Deregulation Act as
14 it applies to air ambulances. (New HOD Policy)
15
- 16 4. That our AMA support stakeholders sharing air ambulance best practices across regions.
17 (New HOD Policy)
18
- 19 5. That our AMA rescind Policy D-130.964, which directed the AMA to conduct the study
20 herein. (Rescind AMA Policy)

Fiscal Note: Less than \$500.

REFERENCES

- ¹ Air Ambulance Data Collection and Transparency Needed to Enhance DOT Oversight. United States Government Accountability Office. July 2017. Available at: <https://www.gao.gov/assets/690/686167.pdf>
- ² Air Medicine: Assessing the Future of Health Care. The Association of Air Medical Services. 2006. Available at: <http://aams.org/wp-content/uploads/2014/01/White-Paper-English.pdf>
- ³ *Supra* note 1.
- ⁴ Air Ambulances. National Association of Insurance Commissioners. January 2018. Available at: https://www.naic.org/cipr_topics/topic_air_ambulances.htm
- ⁵ Vercruysse, GA, et al. Overuse of Helicopter Transport in the Minimally Injured: A Health System Problem that Should be Corrected. *Journal of Trauma and Acute Care Surgery*. 2015. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25710420>
- ⁶ Sherlock, Richard. Protect Air Ambulance Services that Fill the Health Care Access Gap in Rural America. *The Hill*. May 2018. Available at: <http://thehill.com/blogs/congress-blog/healthcare/389347-protect-air-ambulance-services-that-fill-the-health-care>
- ⁷ *Supra* note 1.
- ⁸ Up in the Air: Inadequate Regulation for Emergency Air Ambulance Transportation. Consumers Union. March 2017. Available at: <https://consumersunion.org/wp-content/uploads/2017/04/Up-In-The-Air-Inadequate-Regulation-for-Emergency-Air-Ambulance-Transportation.pdf>
- ⁹ *Supra* note 1.
- ¹⁰ *Id.*
- ¹¹ Air Medical Services Cost Study Report. Prepared for: The Association of Air Medical Services and Members. March 2017. Available at: <http://aams.org/wp-content/uploads/2017/04/Air-Medical-Services-Cost-Study-Report.pdf>
- ¹² *Supra* note 1.
- ¹³ Air Ambulances. National Association of Insurance Commissioners. January 2018. Available at: https://www.naic.org/cipr_topics/topic_air_ambulances.htm
- ¹⁴ *Id.*
- ¹⁵ *Id.*

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (I-18)
Sustain Patient-Centered Medical Home Practices
(Resolution 813-I-17)
(Reference Committee J)

EXECUTIVE SUMMARY

At the American Medical Association (AMA) 2017 Interim Meeting, the House of Delegates referred Resolution 813, “Sustain Patient-Centered Medical Home Practices,” which was introduced by the Michigan delegation. The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House at the 2018 Interim Meeting. Resolution 813-I-17 asked (1) that our AMA amend Policy H-160.918 to urge the Centers for Medicare & Medicaid Services (CMS) to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources; and (2) encourage CMS to subsidize the cost of sustaining Patient-Centered Medical Home (PCMH) designated practices.

The Council believes that primary care and the PCMH are bedrocks of high-quality, patient-centered health care. However, in order to make the transition to a PCMH, practices of all sizes and settings must have the support to confront the challenges of practice transformation. The Council notes that cultural and financial obstacles of becoming a PCMH are substantial and demand significant investment and buy-in. To that end, the Council recommends a set of recommendations recognizing that it is critical to not only have financial support during the initial stages of practice transformation, but also to maintain ongoing funding and continuous cultural and monetary support for PCMH activities.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-18

Subject: Sustain Patient-Centered Medical Home Practices
(Resolution 813-I-17)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

At the American Medical Association (AMA) 2017 Interim Meeting, the House of Delegates referred Resolution 813, “Sustain Patient-Centered Medical Home Practices,” which was introduced by the Michigan delegation. The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House at the 2018 Interim Meeting. Resolution 813-I-17 asked:

(1) That our American Medical Association (AMA) amend Policy H-160.918, “The Patient-Centered Medical Home,” by addition as follows:

Our AMA:

- a. Will urge the Centers for Medicare & Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;
- b. Will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources;
- c. Will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule; and
- d. Will advocate that all health plans and CMS use a single standard to determine whether a physician practice qualifies to be a patient-centered medical home; and

(2) That our AMA work with and encourage CMS to subsidize the cost of sustaining Patient-Centered Medical Home designated practices for practicing physicians.

This report provides background on Patient-Centered Medical Homes (PCMHs), outlines the costs of sustaining a PCMH, discusses the various payment methodologies employed with the model, provides an example of a PCMH, outlines relevant AMA policy and AMA advocacy efforts, and proposes policy recommendations.

BACKGROUND

The PCMH is a team-based practice that is led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.¹ The PCMH model emphasizes population management, team-based care, and care management, particularly for at-risk patients with the objective of having a centralized setting that facilitates partnerships between individual patients, their physicians, and, when appropriate, the patient's family.² The PCMH encompasses five functions and attributes: comprehensiveness, patient-centered, coordinated, accessibility, and quality and safety.³ Evidence suggests that PCMHs improve quality, the patient experience and staff satisfaction, while reducing health care costs.⁴

While recognizing the utility of specialty care medical homes, the Council chose to limit the scope of this report to PCMHs. Improving and investing in primary care has become a major health policy objective, and, for many patients, primary care services are their entry point into the health care system.⁵ As such, primary care is well positioned to help address the fragmentation in the health care system and optimize the delivery of health care. Moreover, the Council believes that primary care physicians are the touchstone of the physician-led health care team and are the gateway to health care.

Building a PCMH requires hard work from all stakeholders including physicians, practice teams, patients, and institutional partners. It requires time, money, dedication, sustained effort, and a cultural shift.⁶

COST OF SUSTAINING A PCMH

Identifying the costs of maintaining PCMH functions can contribute to effective payment reform and sustainability of transformation. The costs for a practice to implement these PCMH services vary depending on factors such as practice size, existing capabilities, characteristics of the patient population, and availability of low-cost or funded resources.⁷

Generally, the most significant cost to sustaining a PCMH is the ongoing cost of maintaining personnel. A recent study assessed the direct personnel costs to 20 primary care practices that differed in PCMH recognition status, ownership, payer mix, and patient populations. The study looked into the practice costs associated with the staffing necessary to deliver PCMH functions per the National Committee for Quality Assurance (NCQA) Standards. The NCQA is the most widely adopted PCMH recognition program.⁸ The study looked at 20 differing primary care practices in Utah and Colorado and found that the incremental costs per full-time equivalent primary care clinician associated with PCMH functions varied across practices with an average of \$7,691 per month in Utah practices and \$9,658 in Colorado practices. Also, the study found that PCMH incremental costs per encounter were \$32.71 in Utah and \$36.68 in Colorado. The average estimated cost per member per month for an assumed panel of 2,000 patients was \$3.85 in Utah and \$4.83 in Colorado. In addition to finding that the staffing and care coordination requirements of a PCMH could have an average incremental cost of \$8600 per month, the study found that smaller practices may be particularly susceptible to increased costs.⁹

Additional insight on practice transformation costs may be gleaned from the traditional cost of electronic health record implementation. According to an extensive study of EHR implementation in Texas-based primary care practices that were not PCMHs, it is estimated that the first-year cost of implementation is about \$162,000 with about \$86,000 in maintenance expenses for a five-physician practice.¹⁰ This figure is likely a significant underestimate of the costs and challenges of

1 implementing a medical home.¹¹ Similar implementation and maintenance costs have been reported
2 across the country including in Massachusetts and New York City.

3
4 Moreover, a recent RAND study found that overall PCMH transformation costs are likely
5 anywhere between \$83,829 and \$346,603 per year and that practice transformation could take
6 several years.¹² Further, the report found that the costs per clinician ranged from \$18,585 to
7 \$93,856, with ongoing median costs at \$147,573 per practice and nearly \$65,000 per clinician.

8 9 PCMH PAYMENT

10
11 PCMHs are a care delivery concept rather than a defined payment model and do not have a defined
12 payment structure. However, many PCMH payment models have similarities. For example,
13 PCMHs often receive payment based on an established fee schedule and supplemental payments
14 for care coordination. The structure of PCMH payment is intended to support and promote practice
15 activities that traditionally do not qualify for payment such as e-mail and phone communications,
16 care coordination, and workflow changes. Therefore, the supplemental payments may be
17 adjustment payments for traditionally non-reimbursed care management services. Other models'
18 supplemental payments are simply additional lump sum payments to incentivize care management.
19 Other models use a capitation-based payment that may include enhanced payment to support
20 medical home activities.¹³ Additionally, many models participate in shared savings.

21 22 EXAMPLES OF A PCMH

23 24 *Comprehensive Primary Care Initiative*

25
26 The Comprehensive Primary Care (CPC) initiative is a four-year multi-payer CMS PCMH
27 initiative intended to strengthen primary care.¹⁴ In initiating CPC, CMS recognized concerns that
28 primary care has been traditionally underfunded and that sufficient payment is critical for the
29 practice-wide changes needed to transform primary care.¹⁵ CPC launched in 2012, and in the
30 ensuing years of the program CMS has partnered with commercial and state health insurance plans
31 to offer population-based care management and shared savings opportunities to participating
32 primary care practices to support the delivery of CPC functions.

33
34 A recent study that looked at the cumulative results of CPC over four years found that CPC
35 practices reported improved primary care delivery, such as care management for high-risk patients,
36 enhanced access, and improved coordination after care transitions.¹⁶ Moreover, CPC slowed
37 growth in emergency department visits by two percent and hospitalizations by two percent relative
38 to the comparison group. Importantly, CPC fostered substantial local collaboration wherein payers
39 and practices came together to collectively work on solutions.¹⁷ This has signaled a paradigm shift
40 wherein payers are now working together in communities to build primary care capacity, and some
41 payers are funding community resources such as data aggregation to drive success. All CPC
42 regions are sharing the lessons learned and best practices to drive further innovation.

43
44 In 2015, the CPC initiative generated \$57.7 million in gross savings for Medicare Parts A and B.
45 Moreover, over half of the participating CPC practices shared in savings of over \$13 million. In
46 addition to generating overall savings, practices in the CPC program exhibited improvement in
47 quality measures including a lowering of hospital admissions and readmission rates. Stakeholders
48 believe that CPC demonstrates the potential for primary care clinicians to redesign their practices
49 to deliver better care to patients and improved outcomes to patients.

1 However, despite decreased utilization and improved outcomes, CPC did not reduce Medicare
2 spending enough to cover care management fees or appreciably improve physician or beneficiary
3 experience or practice performance on a limited set of Medicare claims-based quality measures.¹⁸
4 Comprehensive Primary Care Plus (CPC+), which qualifies as an advanced alternative payment
5 model (APM), was built on the CPC structure and is a five-year PCMH model that launched in
6 2017 in 14 regions across the country. While CPC practices had to achieve savings in total cost of
7 care for their state, CPC+ practices have to achieve good performance on metrics such as reducing
8 ambulatory care sensitive admissions. CPC+ has two tracks. One track is for practices building
9 medical home capabilities, and the second track is for those practices that are already delivering
10 advanced primary care.¹⁹ Moreover, the Physician-Focused Payment Model Technical Advisory
11 Committee (PTAC) recommended to the Secretary of Health & Human Services a proposal
12 developed by the American Academy of Family Physicians (AAFP) for Advanced Primary Care,
13 and the AMA supported this proposal. There is now a second round of CPC+ which expanded the
14 program to more regions.

15
16 CPC+ provides primary care practices with up-front and improved payment in addition to technical
17 assistance.²⁰ Its payment components de-emphasize fee-for-service (FFS) and increase payment to
18 support practice improvement and delivery transformation. Both CPC+ tracks offer three payment
19 components. The first component is a care management fee (CMF) paid per-beneficiary-per-month.
20 The CMF is paid prospectively on a quarterly basis and is based on the complexity of the patient
21 population. The second component is a performance-based incentive payment (PBIP) that is
22 received as a prospective payment at the beginning of each program year in order to meet patient
23 needs and build practice capacity. At the end of the year, if practices do not meet the quality and
24 cost benchmarks, they will repay some or all of the PBIP. The third component is a payment under
25 the Medicare fee schedule. Track 1 practices continue to receive FFS payments while Track 2
26 practices receive a hybrid payment with a prospective portion paid quarterly called the
27 Comprehensive Primary Care Payment (CPCP) coupled with a reduced FFS payment. The CPCP
28 and FFS payments taken together are larger than the practice's historical FFS payment.

30 *CareFirst*

31
32 In 2011, a PCMH program operated by CareFirst BlueCross BlueShield launched, which is the
33 largest coordinated care program of its kind. The program is structured around groups of primary
34 care providers organized into panels of between five to fifteen physicians. These physicians are
35 grouped together to coordinate the care of CareFirst members with the most pressing health care
36 needs, and how the panels operate is largely up to them.²¹ As teams, panels are eligible to earn
37 Outcome Incentive Awards that are paid as increases to their fee schedules based on the level of
38 quality and the savings achieved against projected costs.

39
40 Recognizing that coordinated care often involves services that are not typically compensated under
41 traditional insurance arrangements, CareFirst's PCMH provides for an across-the-board 12
42 percentage point increase in compensation for primary care services. Additionally, the insurer also
43 pays physicians \$200 per patient to develop care plans for high-risk patients and \$100 for every
44 time a care plan needs to be updated.²²

45
46 Importantly, the program is designed to appeal to solo and small group practices. CareFirst
47 understands that the needed investments, particularly IT investments, to create and maintain a
48 PCMH are often cost-prohibitive to physicians in solo or small practice arrangements. Therefore,
49 the program provides physicians with access to all necessary IT to participate in the PCMH.
50 Additionally, CareFirst has dedicated more than 100 nurses across the region to help coordinate
51 care and ensure that the program runs smoothly.²³

Over the course of the program, it has lowered the expected cost of care for CareFirst members by nearly \$1.2 billion.²⁴ In 2017 alone, the CareFirst PCMH helped save \$223 million against the expected cost of care. The savings was largely driven by reductions in hospital admissions and the length of hospital stays. Since the program's inception, all CareFirst members experienced 21.3 percent fewer hospital admissions; 22.5 percent fewer emergency department visits; and 7.8 percent fewer days in the hospital.²⁵

AMA POLICY

Relevant to the subject of this report, Policy H-160.918 addresses the financial aspects of the PCMH model. It urges CMS to work with the AMA and national medical specialty societies to enhance care coordination among providers who provide medical care for patients outside the medical home and urges CMS to assist physician practices seeking to qualify for medical home status with financial and other resources. Specifically, Policy H-160.918 calls for Medicare incentive payments associated with the medical home model to be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule. Moreover, it calls for all health plans and CMS to use a single standard to determine whether a physician practice qualifies to be a patient-centered medical home.

Policy H-160.919 articulates principles of the PCMH and adopts the Joint Principles of Patient-Centered Medical Homes developed and endorsed by primary care societies including the American Academy of Pediatrics, American College of Physicians, American Osteopathic Association, and AAFP, among others. The organizations initially developed these principles to emphasize the patient-physician relationship, physician leadership of a care team and physician responsibility for care coordination, supported by other qualified providers. The policy states that payment should appropriately recognize the added value provided to patients who have a PCMH. The policy calls for the AMA to recognize the value of physician work associated with remote monitoring of patients and clinical data and states that PCMH payment models should allow for separate payments for face-to-face visits. Consequently, Policy H-160.919 supports physician payments that reflect the value of care management work outside of the face-to-face visit and calls for additional payments for achieving measurable and continuous quality improvements and supports a structure for shared savings. The policy promotes a voluntary recognition process for medical homes and supports integrated care across all elements of the health care system. It advocates for quality and safety, patient-centered outcomes, evidence-based decision making, physician engagement in achieving medical outcomes and utilization of information technology (IT). Further, the policy also advocates for access to care through systems such as open scheduling, expanded hours and new options for communicating with patients.

Policy H-450.931 supports the move to APMs and calls for the AMA to provide physician practices with support and guidance in the transition. Policy H-385.908 calls for the AMA to work with organizations to improve the availability and use of health IT, including continuing to expand technical assistance and developing IT systems that support and streamline clinical participation. Policy H-385.908 also urges CMS to limit financial risk to costs that physicians participating in APMs have the ability to influence or control.

AMA ACTIVITY

The AMA continues to work to assist physicians with the requirements and incentives contained in the Medicare Access & CHIP Reauthorization Act (MACRA), which includes the development and

1 successful implementation of PCMHs. The AMA has been active in educational activities
2 including webinars and regional conferences for physicians and staff and will be continuing these
3 activities. Recent AMA advocacy activity has called for improvements in the methodologies
4 behind APMs to reduce practice barriers and enable more physicians to participate. The AMA has
5 urged CMS to enhance proposals that provide credit for and promote medical homes and APMs.
6 Therefore, the AMA has repeatedly advocated for CMS to extend the CPC+ model nationwide for
7 all of Medicare. Further, the AMA has called for an increase in medical home flexibility and to
8 expand medical home eligibility to specialty medical homes. Additionally, the AMA has called for
9 the lower financial risk requirements available for patient-centered primary care medical homes to
10 be extended to specialty medical homes. Moreover, the AMA continues to advocate for proper risk
11 adjustment in APMs and has urged CMS to prevent stringent two-sided risk requirements from
12 being extended to primary care medical homes serving vulnerable populations, such as children
13 with Medicaid coverage.

14
15 Additionally, the AMA is advocating for PCMHs to earn more credit in the Merit-Based Incentive
16 Payment System (MIPS). PCMHs can be recognized by a variety of organizations and have this
17 recognition count as their Improvement Activity under MIPS. However, because the Improvement
18 Activity score is only weighted at 15 percent of the total score so it does not count for a significant
19 percentage of overall score. However, the AMA has advocated that practices that go to the effort of
20 transforming to PCMHs should be able to utilize their PCMH status for more credit in MIPS.

21
22 AMA advocacy efforts are also focused on the PTAC and Physician-Focused Payment Models
23 (PFPs). The AMA attends and makes public comments at meetings of the PTAC, submits
24 comments on its draft documents and stakeholder proposals, and works with specialty societies
25 developing APM proposals to help address challenges they face in APM design. Additionally, the
26 AMA convenes workshops and a workgroup to bring together many of the leading physicians who
27 are working on PFP proposals to discuss potential solutions to these issues.

28
29 In its advocacy efforts, the AMA has highlighted that some practices are effectively doing the work
30 of the PCMH but are not being compensated for its activities or recognized because the
31 certification process is arduous and expensive. To that end, the AMA has advocated for CMS to
32 recognize programs that accredit medical homes based on the advanced primary care functions,
33 including state-based, payer-sponsored, and regional medical home recognition programs.
34 Moreover, the AMA has stated that physicians should not be required to pay a third party
35 accrediting body to receive recognition as a PCMH. Recognition or certification by an accrediting
36 body may not necessarily capture the actual advanced primary care functions.

37 38 DISCUSSION

39
40 The value of primary care is often underemphasized relative to other parts of the health care
41 system.²⁶ However, payers and other stakeholders are increasingly recognizing the need to
42 strengthen primary care and to help reduce overall health care costs and improve care quality.
43 Accordingly, the Council recommends reaffirming Policy H-160.919 that contains principles of the
44 PCMH including that payment should appropriately recognize the added value provided to patients
45 who have a PCMH and the additional physician and team work associated with participating in a
46 PCMH. The Council also recommends reaffirming Policy H-385.908 stating that physicians should
47 only be held responsible for costs that they can reasonably control.

48
49 Additionally, recognizing that flexibility is integral to ensuring that PCMHs are designed in ways
50 that improve care for patients and are feasible for physicians to implement, the Council
51 recommends rescinding Part 4 of Policy H-160.918, which states that the AMA will advocate that

all health plans and CMS use a single standard to determine whether a physician practice qualifies to be a PCMH because the AMA has continued to support increased medical home flexibility. Rescinding this section of the policy would support flexibility in practices to implement medical home functions with methods best suited for their practice designs and patient populations.

As Resolution 813-I-17 recognizes, adequate compensation for ongoing and incremental costs is critical for practices to sustain PCMH functions. Not only are the costs of implementation and maintenance significant, but also, care innovations such as telemedicine that increase access and improve care quality also may be expensive. Therefore, the Council recommends advocating that all payers support medical home transformation and maintenance efforts recognizing that payer support is crucial to the long-term sustainability of delivery reform. Similarly, the Council believes many stakeholders have a role to play in assisting PCMHs and thus recommends encouraging health agencies, health systems, and other stakeholders to support and assist medical home transformation and maintenance efforts. The Council believes that these stakeholders have a critical role to play in supporting PCMHs financially, with technical assistance, and culturally by increasing awareness of the PCMH and improving patient education.

Primary care and the PCMH are acknowledged as bedrocks of high-quality, patient-centered health care. However, in order to make the transition to a PCMH, practices of all sizes and settings must have the support to confront the challenges of practice transformation. The cultural and financial obstacles of becoming a PCMH are substantial and demand significant investment and buy-in. It is critical to not only have financial support during the initial stages of practice transformation but also to maintain ongoing funding and continuous cultural and financial support for PCMH activities.

The Council recognizes that both PCMHs and specialty care medical homes play an increasingly important role in an evolving payment and delivery system. As such, the Council will continue to monitor primary care and specialty medical homes.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 813-I-17 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-160.919 that contains principles of the Patient-Centered Medical Home (PCMH) including that payment should appropriately recognize the added value provided to patients who have a PCMH and the additional physician and team work associated with participating in a PCMH. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy H-385.908 urging that financial risk should be limited to costs that physicians have the ability to influence or control. (Reaffirm HOD Policy)
3. That our AMA amend Policy, H-160.918, "The Patient-Centered Medical Home," by addition and deletion as follows:

Our AMA:

- a. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;

- 1 b. will urge CMS to assist physician practices seeking to qualify for and sustain medical
- 2 home status with financial and other resources; and
- 3 c. will advocate that Medicare incentive payments associated with the medical home model
- 4 be paid for through system-wide savings – such as reductions in hospital admissions and
- 5 readmissions (Part A), more effective use of pharmacologic therapies (Part D), and
- 6 elimination of government subsidies for Medicare Advantage plans (Part C) – and not be
- 7 subject to a budget neutrality offset in the Medicare physician payment schedule;~~;~~ and
- 8 d. ~~will advocate that all health plans and CMS use a single standard to determine whether a~~
- 9 ~~physician practice qualifies to be a patient-centered medical home.~~ (Modify Current HOD
- 10 Policy)
- 11
- 12 4. That our AMA advocate that all payers support and assist PCMH transformation and
- 13 maintenance efforts at levels that provide a stable platform for optimized patient-centered care
- 14 recognizing that payer support is crucial to the long-term sustainability of delivery reform.
- 15 (New HOD Policy)
- 16
- 17 5. That our AMA encourage health agencies, health systems, and other stakeholders to support
- 18 and assist patient-centered medical home transformation and maintenance efforts at levels that
- 19 provide a stable platform for optimized patient-centered care. (New HOD Policy)

Fiscal Note: Less than \$500

REFERENCES

- ¹ Patient-Centered Medical Home. American College of Physicians. Available at: <https://www.acponline.org/practice-resources/business-resources/payment/models/pcmh>
- ² What is the Patient-Centered Medical Home? American College of Physicians. Available at: <https://www.acponline.org/practice-resources/business/payment/models/pcmh/understanding/what-pcmh>
- ³ Defining the PCMH. Agency for Healthcare Research and Quality. Available at: <https://pcmh.ahrq.gov/page/defining-pcmh>
- ⁴ Patient-Centered Medical Home (PCMH) Recognition. National Committee for Quality Assurance. Available at: <http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh>
- ⁵ The Patient-Centered Medical Home: Frequently Asked Questions (FAQ). Patient-Centered Primary Care Collaborative. Available at: <https://www.pcpcc.org/about/medical-home/faq>
- ⁶ The Medical Home. American Academy of Family Physicians. Available at: <https://www.aafp.org/practice-management/transformation/pcmh.html>
- ⁷ PCMH Costs, Benefits and Incentives. American College of Physicians. Available at: <https://www.acponline.org/practice-resources/business-resources/payment/models/pcmh/pcmh-costs-benefits-and-incentives>
- ⁸ *Supra* note 4.
- ⁹ Magill, Michael, et. al. The Cost of Sustaining a Patient-Centered Medical Home: Experience from 2 States. *Annals of Family Medicine*. September/October 2015. Available at: <http://www.annfammed.org/content/13/5/429.full>
- ¹⁰ Fleming, Neil, et. al. The Financial and Nonfinancial Costs of Implementing Electronic Health Records in Primary Care Practices. *Health Affairs*. March 2011. Available at: <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2010.0768>
- ¹¹ Klein, David, et. al. The Patient-Centered Medical Home: A Future Standard for American Health Care? *Public Administration Review*. 2013. Available at: http://www.columbia.edu/~nl2320/doc/Patient_Centered_Medical_Home_Final%20online.pdf
- ¹² Martsolf GR, et. al. Cost of Transformation among Primary Care Practices Participating in a Medical Home Pilot. *Journal of General Internal Medicine*. 2016. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/26714484>

¹³ Paying for the Medical Home: Payment Models to Support Patient-Centered Medical Home Transformation in the Safety Net. Safety Net Medical Home Initiative. Available at: <http://www.safetynetmedicalhome.org/sites/default/files/policy-brief-1.pdf>

¹⁴ Comprehensive Primary Care Initiative. Centers for Medicare and Medicaid Services. Available at: <https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/>

¹⁵ *Id.*

¹⁶ Peikes, Deborah, et. al. The Comprehensive Primary Care Initiative: Effects on Spending, Quality, Patients, and Physicians. Health Affairs. June 2018. Available at: [https://www.mathematica-mpr.com/our-publications-and-findings/publications/ja-the-comprehensive-primary-care-initiative-effects-on-spending-quality-patients-and-physicians?utm_source=SilverpopMailing&utm_medium=email&utm_campaign=CPC%20Plus%2005%2023%2018%20\(1\)&utm_content=&spMailingID=19616018&spUserID=MjMzODIxOTA5MDUzS0&spJobID=1261438220&spReportId=MTI2MTQzODIyMAS2](https://www.mathematica-mpr.com/our-publications-and-findings/publications/ja-the-comprehensive-primary-care-initiative-effects-on-spending-quality-patients-and-physicians?utm_source=SilverpopMailing&utm_medium=email&utm_campaign=CPC%20Plus%2005%2023%2018%20(1)&utm_content=&spMailingID=19616018&spUserID=MjMzODIxOTA5MDUzS0&spJobID=1261438220&spReportId=MTI2MTQzODIyMAS2)

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ Comprehensive Primary Care Plus (CPC+). American Academy of Family Physicians. Available at: <https://www.aafp.org/practice-management/transformation/cpc-plus.html>

²⁰ *Id.*

²¹ CareFirst Patient-Centered Medical Home Program Nets \$1.2B In Savings Since 2011. PR Newswire. Available at: <https://www.prnewswire.com/news-releases/carefirst-patient-centered-medical-home-program-nets-1-2b-in-savings-since-2011--300673361.html>

²² Schilling, Brian. As CareFirst Tweaks the Medical Home, Doctors Flock and Costs Dip. The Commonwealth Fund. Available at: <https://www.commonwealthfund.org/publications/newsletter/carefirst-tweaks-medical-home-doctors-flock-and-costs-dip>

²³ *Id.*

²⁴ *Supra* note 21.

²⁵ *Id.*

²⁶ *Supra* note 18.

REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (I-18)
The Site-of-Service Differential
(Resolution 817-I-17)
(Reference Committee J)

EXECUTIVE SUMMARY

The site-of-service differential is a longstanding payment policy issue stemming from the Medicare program's use of separate payment systems in its rate-setting calculations. This report addresses disparities in Medicare Part B payment for covered items and services across outpatient care settings, including the offices of physicians and other health professionals, hospital outpatient departments (HOPDs), and ambulatory surgical centers (ASCs). Most outpatient procedures can be provided across multiple clinical settings, and although the choice of outpatient site for many services has no discernible effect on patient care, it significantly impacts Medicare's payment for such services and patient cost-sharing expenses. Generally speaking, Medicare pays higher rates for outpatient services performed in hospital facilities than to physician offices or ASCs for furnishing the same service to similar patients. The scope of the payment differential varies, depending on the procedure.

This report describes ongoing disparities in Medicare payment for outpatient procedures across care settings, explains how Medicare determines payments for outpatient services in each setting, compares Medicare physician payment updates to inflation, and summarizes relevant American Medical Association (AMA) policy and activity. The Council recommends reaffirmation of existing AMA policy as well as new policy addressing the site-of-service differential. The Council recommends that the AMA support Medicare payment policies for outpatient procedures that are site-neutral without lowering total Medicare payments. The Council further recommends that the AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting.

While the focus of this report is the site-of-service differential, the Council recognizes that broader physician payment issues must also be addressed. To help build the case for future Medicare payment reforms that support site-neutrality without lowering total Medicare payments, the Council recommends that the AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-18

Subject: The Site-of-Service Differential
(Resolution 817-I-17)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

At the 2017 Interim Meeting, the House of Delegates referred Resolution 817-I-17, “Addressing the Site of Service Differential,” introduced by the New Mexico Delegation, for report back at the 2018 Annual Meeting. The Board of Trustees assigned this item to the Council on Medical Service. Resolution 817-I-17 asked the American Medical Association (AMA) to:

- 1) Study the site-of-service differential with a report back no later than the 2018 Interim Meeting, including: a) the rising gap between independent practice expenses and Medicare reimbursement, taking into account the costs of the regulatory requirements; b) the increased cost of medical personnel and equipment, including electronic health record (EHR/EMR) purchase, software requirements, and ongoing support and maintenance; c) the expense of maintaining hospital-based facilities not common to independent practices, such as burn units and emergency departments, and determine what payment should be provided to cover those explicit costs; and d) the methodology by which hospitals report their uncompensated care, and the extent to which this is based on actual costs, not charges; and
- 2) Advocate for a combined health care payment system for patients who receive care that is paid for by the Centers for Medicare & Medicaid Services (CMS), that: a) follows the recommendation of MedPAC to pay “site-neutral” reimbursement that sufficiently covers practice expenses without regard to whether services are performed under the Hospital Outpatient Prospective Payment System (OPPS) or the Physician Fee Schedule (PFS); b) pays appropriate facility fees for both hospital owned facilities and independently owned non-hospital facilities, computed using the real costs of a facility based on its fair market value; and c) provides independent practices with the same opportunity to receive reimbursement for uncompensated care as is provided to hospital owned practices.

This report describes ongoing disparities in Medicare payment for outpatient procedures across care settings, summarizes relevant AMA policy and activity, and presents policy recommendations addressing the outpatient site-of-service differential.

BACKGROUND

The site-of-service differential is a longstanding payment policy issue stemming from the Medicare program’s use of more than a dozen separate payment systems—some of which are based on the location where services are provided—in its rate-setting calculations. Several of these payment systems base payments on the location where services are provided. This report addresses disparities in Medicare Part B payment for covered items and services across outpatient care

settings, including the offices of physicians and other health professionals, hospital outpatient departments (HOPDs), and ambulatory surgical centers (ASCs). Most outpatient procedures can be provided across multiple clinical settings, and although the choice of outpatient site for many services has no discernible effect on patient care, it significantly impacts Medicare’s payment for such services and patient cost-sharing expenses. Generally speaking, Medicare pays higher rates for outpatient services performed in hospital facilities than to physician offices or ASCs for furnishing the same service to similar patients. The scope of the payment differential varies, depending on the procedure, and in some cases may be difficult to ascertain because units of payment differ across payment systems. Furthermore, the payment differential may extend beyond primary services to entire episodes of care. One analysis found that payments for cardiovascular imaging, colonoscopy, and evaluation and management services are higher when furnished in HOPDs, and that the higher payments extend to related services provided to patients as part of episodes of care associated with these procedures.¹ The variations in payment persisted after controlling for patient demographic and severity differences, thereby attributing a substantial portion of the pay disparities to the payment systems themselves.²

The Council previously studied aspects of the site-of-service differential—and confirmed that Medicare payments for many procedures are higher when furnished in HOPDs—during the development of Council Report 3-A-13, “Payment Variations across Outpatient Sites of Service,” and Council Report 3-A-14, “Medicare Update Formulas Across Outpatient Sites of Service.” Council Report 3-A-13 compared Medicare payments for five common procedures performed across outpatient settings, and built upon the AMA’s substantial policy supporting site neutrality by encouraging private payers to incentivize outpatient care delivery in lower-cost settings. Council Report 3-A-14 found that existing Medicare payment formulas have contributed to growth in the volume of outpatient services provided in hospitals and hospital-owned facilities, even when these services can be safely performed in lower-cost settings. Council Report 3-A-14 focused primarily on equalizing payments between HOPDs and ASCs because payments to these settings are based on the same Medicare payment system (OPPS), with ASCs paid at lower rates. Developing policy addressing payment disparities between hospital-owned facilities and independent physician practices is more complex because, under current statute, the rate-setting for items and services in these outpatient sites is based on separate Medicare payment systems that calculate payments for different units of service.

Medicare Payment Rates for Off-Campus Provider-Based Hospital Departments

For many years, higher payments to HOPDs likely incentivized the sale of physician practices and ASCs to hospitals because acquired facilities meeting certain criteria (eg, located within 35 miles of the hospital) were routinely converted to HOPDs and allowed to charge higher OPPS rates for services performed at these off-campus facilities. However, a provision in the Bipartisan Budget Act of 2015 (BBA) disallowed provider-based billing by hospitals for newly acquired physician practices and ASCs. The Congressional Budget Office estimated in 2015 that this provision would save \$9.3 billion over 10 years.³ Beginning in 2017, off-campus entities acquired after enactment of the BBA—in November 2015—were no longer permitted to bill for services under the OPPS, and instead required to bill under the applicable payment system (PFS). Since 2017, CMS has paid for services at non-excepted off-campus provider-based hospital departments using a PFS relativity adjuster that is based on a percentage of the OPPS payment rate. Currently, CMS regulations stipulate that these services be paid 40 percent of OPPS payment rates,⁴ although provider-based departments acquired prior to November 2015 continue to bill under the OPPS. In July 2018, CMS proposed extending site-neutral payments to include clinic visits provided at off-campus provider-based hospital departments acquired prior to November 2015, that were excepted from the BBA provision.⁵ CMS proposed to reduce payment rates for clinic visits at hospital-owned physician

practices located off the hospital campus from \$116 with \$23 cost-sharing to \$46 with \$9 cost-sharing.⁶ At the time this report was written, the CMS proposal had not been finalized.

Hospital Employment of Physicians

It is possible that Medicare payment reductions for services provided at off-campus provider-based hospital departments acquired after November 2015 have contributed to a leveling off of hospital acquisitions of physician practices. Data from the AMA's 2012, 2014, and 2016 Physician Practice Benchmark Surveys, which yield nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week, demonstrate recent stability in the ownership structure of physician practices. Analyses of the surveys found that the share of physicians who worked directly for a hospital or in practices that were at least partially owned by a hospital remained unchanged between 2014 and 2016—at 33 percent.⁷ This percentage represented an increase from 29 percent in 2012. Although detailed information on practice ownership structure is not available for years prior to 2012, research suggests that in 2007-2008, only 16 percent of physicians worked directly for a hospital or in practices that were at least partially owned by a hospital.⁸

Medicare Payment Systems for Outpatient Services

The separate methodologies used for rate-setting under the OPPS and the PFS are at the root of the outpatient site-of-service differential (see Table 1). Under current law, Medicare's payment systems do not account for the fact that many outpatient services can be provided safely and at lower cost to Medicare and patients outside of the hospital setting. Because there is no linkage between OPPS and PFS payment systems, Medicare may pay dramatically different rates for the same services based on whether they are provided in hospital facilities or physician offices.

Table 1: Medicare Payment Systems for Physician Offices, Hospital Outpatient Departments, and Ambulatory Surgical Centers

Site	Physician Office	Hospital Outpatient Department	Ambulatory Surgical Center
Payment System	Physician fee schedule (non-facility rate)	Physician fee schedule (facility rate) plus OPPS rate	Physician fee schedule (facility rate) plus ASC payment system (based on relative weight under the OPPS)
Basis for Updates	Medicare Access and CHIP Reauthorization Act (MACRA)	Hospital market basket	Consumer price index for all urban consumers
Unit of Payment	Individual service	Ambulatory payment classification	Ambulatory payment classification

For services furnished in physician and other practitioner offices, Medicare pays for units of service billed under the PFS. There is a single payment for each service which amounts to 80 percent of the PFS rate, with the patient responsible for cost-sharing that covers the remaining 20 percent. For procedures provided in hospital outpatient departments, Medicare pays a reduced physician fee under the PFS plus a facility fee established under the OPPS. Patients are responsible for cost-sharing associated with both the physician fee and the facility fee. Whereas providers generally receive separate payments for each service under the PFS, services paid under the OPPS

are grouped together into ambulatory payment classifications based on clinical and cost similarities.

Formulas unique to each payment system are then used to annually adjust payment rates for inflation, which may actually widen existing payment disparities. HOPD updates are based on the hospital market basket, and annual updates to the PFS were established by MACRA. The Medicare program currently uses the consumer price index for all urban consumers (CPI-U) to annually update ASC payment rates, although—consistent with AMA policy—CMS recently proposed updating ASC rates using the hospital market basket instead of the CPI-U for a five-year period. If this proposal is finalized, CMS will examine whether the change incentivizes a migration of services to lower-cost ASC settings over the five-year period.

Medicare Physician Payment Updates Compared to Inflation

Medicare payments for physician services have for many years failed to keep pace with the actual costs of running a practice. From 2001 to 2017, Medicare physician pay rose just six percent (0.4 percent per year on average), although Medicare's index of inflation in the cost of running a practice increased 30 percent (1.7 percent per year on average). Economy-wide inflation, as measured by the Consumer Price Index, has increased 39 percent over this time period.⁹ Adjusted for inflation in practice costs, Medicare physician pay has declined 19 percent from 2001 to 2017, or by 1.3 percent per year on average.

During the same time period, Medicare hospital pay has increased roughly 50 percent, with average annual increases of 2.6 percent per year for inpatient services, and 2.5 percent per year for outpatient services. Medicare skilled nursing facility pay has increased 51 percent between 2001 and 2017, or 2.6 percent per year.¹⁰ There are some significant differences between hospitals and physician practices that may lead to higher costs of providing care in HOPDs. For example, hospitals maintain operations 24/7, and also standby capacity for handling emergencies, although payment for standby costs is included in Medicare's payment for emergency department services.¹¹

Uncompensated/Inadequately Compensated Physician Practice Expenses

The need for sustainable physician payments under the Medicare program is compounded by numerous uncompensated administrative tasks that are extremely costly to practices and reduce time spent with patients, yet increase the work necessary to provide medical services. CMS alone publishes thousands of pages of regulations affecting physician practices every year, including rules governing the reporting of quality measures, the Recovery Audit Contractor (RAC) Program, MACRA implementation, and Medicare's numerous payment systems. Utilization management has become so burdensome that in 2017 the average physician reported completing 29 prior authorizations per week, a process that required 14.6 hours of work or the equivalent of two business days.¹² In addition to navigating a plethora of payer protocols and utilization management requirements, physician practices have to purchase, manage and update electronic health records (EHRs) to document the care they are providing. Incorporating EHR technology into practice workflows is costly and consumes a significant amount of physician time that could otherwise be spent with patients. Notably, a 2016 *Annals of Internal Medicine* study found that, for every hour of clinic time spent with patients, physicians spend approximately two hours per day during office hours, and another one to two hours outside of office hours, on EHR and desk work.¹³ According to a 2016 *Health Affairs* study, physician practices across four common specialties spend over \$15.4 billion annually to report quality measures, with physicians on average spending 2.6 hours per week on these measures.¹⁴ Many physician practices also provide high-technology outpatient

1 services (ie, infusions and/or imaging) that were once the domain of hospitals and for which
2 practices are not adequately compensated under the PFS.

3
4 Hospitals that treat a disproportionate share of low-income patients receive additional payments to
5 offset the financial effects of treating these patients. Traditionally, disproportionate share hospital
6 (DSH) payments were based on hospitals' share of Medicaid patients and Medicare patients with
7 Social Security Disability Insurance. Beginning in 2014, DSH payments were calculated as 25
8 percent of that payment amount, and hospitals also began receiving uncompensated care payments
9 from a pool of funds equal to 75 percent of the DSH payment received under the traditional
10 formula, minus an amount that increases in proportion to decreases in the uninsured population.¹⁵
11 Part of this pool is distributed to hospitals based on the share of uncompensated care they
12 provide.¹⁶ Physician practices are not eligible for either DSH or uncompensated care payments,
13 despite the fact that most physicians (89 percent) treat Medicare patients and, in 2016, most also
14 had Medicaid (82.6 percent) and uninsured (75.6 percent) patients.¹⁷ There have been questions as
15 to whether Medicare DSH and uncompensated care payments are appropriate proxies for the
16 amount of uncompensated care provided by hospitals, and Medicare Payment Advisory
17 Commission (MedPAC) has recommended that uncompensated care payments to hospitals be
18 based on actual uncompensated care data.

19
20 *Expert Policy Recommendations for Reducing Payment Variations*

21
22 To address shifts in outpatient care to higher cost sites-of-service (eg, hospital-owned facilities),
23 which increase costs to the Medicare program and its patients, several policy options have been
24 proposed to equalize payments across settings for certain services. After the MedPAC found that
25 payments to HOPDs for 15-minute evaluation and management visits were 80 percent higher than
26 payments to physician offices for the same service, it recommended in 2012 that HOPD payments
27 for these services be reduced to physician office rates.¹⁸ In 2014, MedPAC recommended that
28 differences in payment rates between HOPDs and physician offices be eliminated by reducing
29 HOPD rates for 66 ambulatory payment classifications. These groups of services were selected by
30 MedPAC based on patient severity being similar in HOPDs and physician offices, and because they
31 are frequently furnished in physician offices.¹⁹

32
33 A 2011 RAND Health analysis examined several policy options for addressing Medicare payment
34 differentials across outpatient sites, such as increasing uniformity in the units of service across
35 payment systems, and basing payment rates on the least costly setting. This analysis concluded that
36 basing payment differentials on justifiable cost differences would promote payment equity across
37 outpatient sites-of-care and value-based care, but would also be administratively burdensome.
38 Determining justifiable cost differences would also be impractical.²⁰

39
40 The Office of the Inspector General (OIG) has also recommended reductions in HOPD payment
41 rates to those of less costly settings, and has even recommended pursuing legislative changes to
42 OPPI budget neutrality provisions so that payment rates to HOPDs could be reduced without
43 offsetting those reductions with payment increases.²¹ Several administrations have also proposed
44 equalizing payment variations via budget proposals, and President Trump's budget published in
45 February 2018 proposed applying physician office rates to all hospital-owned physician offices
46 located off the hospital campus. As stated previously, CMS has proposed extending site-neutral
47 payments to include clinic visits provided at off-campus hospital-owned facilities.

48
49 It is clear that most of the policy options identified to date have recommended leveling the site-of-
50 service playing field by reducing payment rates to the amounts payable in the least costly
51 outpatient setting. Although CMS has not implemented the MedPAC or OIG recommendations, in

2014 the agency identified approximately 200 services for which physician office payments were higher than HOPD or ASC rates and proposed lowering physician fees for these services. Most experts, including MedPAC, believe that Medicare payments to physician offices, HOPDs and ASCs will continue to be based on the program's current payment systems for the foreseeable future. The combined payment system called for in the second resolve of Resolution 817-I-17 would require legislative changes that would face significant obstacles in a Congress that is hamstrung by partisanship and budgetary concerns. Opponents, including hospitals and other stakeholders whose payment rates would be affected, are likely to counter that physicians' facility costs are already covered through the practice expense component of the PFS.

Moreover, convincing Congress to redesign Medicare's payment systems would be extremely difficult. Given existing pressures to reduce health care costs, there is also a risk that advocating for a combined payment system could encourage Congress or CMS to design a system that lowers payments to all providers and/or does not provide relief for independent physician practices. CMS could also choose to impose the OPFS payment system, on which HOPD and ASC payments are based, on physician practices. Doing so would mean that units of service currently paid separately under the PFS would be grouped together into an ambulatory payment classification, which is the unit of payment under the OPFS.

Updating Physician Practice Expenses Paid under the PFS

Alternatively, the Council considered requesting that CMS update the inputs used to calculate the indirect practice expense component of the PFS, which is analogous to OPFS facility fees and which is based in part on 10-year-old survey data that no longer reflect current practice arrangements or the relative costs of running a practice. Updated data are urgently needed to ensure that practice expenses under the PFS more accurately reflect the costs to physician practices of furnishing office-based services. However, it is important to recognize that any practice expense changes under the current system will need to be budget neutral.

Payments under the PFS are required by statute to be based on national uniform relative value units (RVUs) that account for the relative resources used in furnishing a service.²² In brief, RVUs are established for work, practice expense, and malpractice expense categories, which are adjusted for geographic cost variations. These values are multiplied by a conversion factor to convert the RVUs into payment rates. Statutory budget neutrality provisions require that annual adjustments to the RVUs that increase by more than \$20 million must be offset by cuts in other RVUs or through a cut in the conversion factor.²³

CMS establishes separate facility-and nonfacility-based practice expense RVUs for services furnished in facility settings (eg, HOPD or ASC) and in nonfacility settings (eg, physician offices). Facility-based RVUs are generally lower than nonfacility-based RVUs, so that HOPDs and ASCs receive facility payments under the OPFS whereas physician offices receive a facility fee under the PFS. Nonfacility practice expense RVUs are intended to reflect all of the direct and indirect practice expenses associated with furnishing a service in a physician office.

Direct expenses include cost inputs related to clinical labor, medical equipment and supplies. Indirect expenses include administrative labor, rent, billing services, and other office-related expenses that cannot be directly attributed to a service. In its proposed rule for CY 2019, CMS proposed updated pricing recommendations for 2,017 supply and equipment items currently used as direct practice expense inputs. The proposal is based on a report from a CMS contractor that used market research resources and methodologies to determine the updated prices.²⁴ As described in the following section, survey data are used by CMS to determine the indirect practice expenses

incurred per hour worked.²⁵ Each procedure is then assigned practice expense RVUs that are supposed to reflect the practice expenses required to provide the service relative to those required to provide other procedures.

The need for accurate data on practice costs is significant, considering many of the points raised in Resolution 817-I-17. Physician practices have experienced significant increases in practice expenses due to cumbersome regulations, quality measure requirements, EHRs (purchases, software upgrades, ongoing support and maintenance), complex payment and utilization management protocols, costly equipment used to provide, for example, imaging or infusions, and other costs that have changed dramatically since practice expense survey data was collected a decade ago. It may also be challenging for many independent and small group practices to accurately determine their total practice expenses when completing surveys about the costs of running a practice.

The Physician Practice Information Survey (PPI Survey)

In 2010, CMS began basing indirect practice expenses on the PPI Survey, a multispecialty, nationally representative survey of both physicians and non-physician practitioners paid under the PFS that was administered by the AMA over a period of time in 2007 and 2008. The PPI Survey collected data from 3,656 respondents across 51 medical specialties and health care professional groups.²⁶ Participating practices were asked to fill out expense worksheets that itemized expenses such as payroll, supplies and equipment. They were also asked about the costs of managing a practice, charity care, time spent on quality improvement activities, and the acquisition, operating and maintenance costs associated to EHRs. PPI Survey data were used by CMS to confirm the accuracy of PFS practice expense data. As required by statute, CMS uses medical oncology supplemental survey data from 2003 for practice expenses per hour for oncology drug administration services. For specialties that did not participate in the PPI Survey, CMS develops proxy practice expense values by crosswalking practice expense data from specialties providing similar services.²⁷

Section 220 of the Protecting Access to Medicare Act of 2014, allocates funds for CMS "...to collect and use information on physicians' services in the determination of relative values in the formulae for setting physician's fees."²⁸ The AMA/Specialty Society RVS Update Committee and other entities have encouraged CMS to use these funds to conduct an updated survey on practice expense data. Even CMS has expressed concerns regarding the accuracy of the outdated data used to determine practice expense RVUs but, lacking other sources, the agency continues using PPI Survey data to inform physician payments under the PFS. The collection of physician practice expense data is a necessary first step which will enable comparisons to hospital cost and payment metrics and provide insight into the costs of care provided in hospital-owned and independently-owned practices.

AMA POLICY

The AMA has substantial and long-standing policy supporting equitable payments across outpatient sites of service. Policy H-240.993 calls for equity of payment between services provided by hospitals on an outpatient basis and similar services in physicians' offices. AMA policy also supports defining Medicare services consistently across settings and encouraging the CMS to adopt payment methodologies that assist in leveling the playing field across all sites of service (Policy D-330.997).

Policy H-330.925 encourages CMS to fairly pay physicians for office-based procedures and adopt a site-neutral payment policy for hospital outpatient departments and ambulatory surgical centers; advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; advocates that in place of the CPI-U, CMS use the hospital market basket index to annually update ASC payment rates; and encourages the use of Current Procedural Terminology (CPT) codes across all sites of service as the only acceptable approach to payment methodology.

Policy H-400.957 encourages CMS to expand the extent and amount of reimbursement for procedures performed in the physician office, to shift more procedures from the hospital to the office setting, which is more cost effective, and to seek to have practice expense RVUs reflect the true cost of performing office procedures. Policy H-400.966 directs the AMA to aggressively promote the compilation of accurate data on all components of physician practice costs, and the changes in such costs over time, as the basis for informed and effective advocacy concerning physician payment under Medicare.

Policy D-240.994 directs the AMA to work with states to advocate that third-party payers be required to assess equal or lower facility coinsurance for lower-cost sites of service; publish and routinely update pertinent information related to patient cost-sharing; and allow their plan's participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient. Furthermore, AMA policy urges private third-party payers to implement coverage policies that do not unfairly discriminate between hospital-owned and independently owned outpatient facilities with respect to payment of facility costs (Policy H-240.979). Policy H-390.849 directs the AMA to advocate for the adoption of physician payment reforms that promote improved patient access to high-quality and cost-effective care, do not require budget neutrality within Medicare Part B, and are based on payment rates that are sufficient to cover the full cost of sustainable medical practices.

AMA ACTIVITY

Enhancing Practice Efficiency and Promoting Physician Satisfaction

A strategic focus area within the AMA is working diligently to help physicians succeed in a rapidly changing health care environment. From advancing health care delivery and payment reforms that promote affordable care to restoring and preserving physician professional satisfaction, the AMA is driving practice transformation by translating regulatory requirements into actionable information; developing and disseminating practice improvement strategies and tools; establishing national benchmarks for physician burnout, leading to organizational level changes; and producing evidence-based research. To accelerate advancements in—and support for—physician and care team well-being, the AMA sponsors conferences that bring top investigators and thought leaders together to debate and advance health policies.

Encouraging Value-Based Payment

The AMA has been working for several years to encourage the development and implementation of Medicare payment models that will improve the financial viability of physician practices in all specialties, and help independent practices of all sizes remain independent; give physicians more resources and greater flexibility to deliver appropriate care to their patients; minimize administrative burdens that do not improve the quality of patient care; enable physicians to help control aspects of health care spending that they can influence, rather than having Medicare use inappropriate mechanisms to control costs such as payment cuts, prior authorization or non-

1 coverage of services. Since the passage of MACRA, the AMA has been accelerating its efforts to
2 help national medical specialty societies and other physician organizations to develop, refine and
3 implement alternative payment models (APMs) that will achieve these goals. Ideally, payment
4 under these models should extend across sites of care.²⁹ AMA policy (Policy H-385.913)
5 recognizes that APMs should provide adequate resources to support the services physician
6 practices need to deliver to patients. The AMA has urged the US Department of Health and Human
7 Services to reconsider testing a number of APMs as recommended by the Physician-Focused
8 Payment Model Technical Advisory Committee.³⁰

9 10 *Improving Price Transparency*

11
12 As the health care market evolves, patients are increasingly becoming active consumers of health
13 care services rather than passive recipients of care in a market where price is often unknown until
14 after the service is rendered. Achieving meaningful price transparency can help lower costs and
15 empower patients to make informed care decisions, including decisions about where to receive
16 certain outpatient services. Many patients may not be able to readily distinguish between hospital-
17 owned and independent practices, and may not understand how choice of outpatient setting impacts
18 their cost-sharing expenses. The AMA supports measures to expand the availability of health care
19 pricing information that allows patients and their physicians to make value-based decisions when
20 patients have a choice of provider or facility.

21 22 DISCUSSION

23
24 The AMA has long supported and advocated for fair, equitable and adequate Medicare payments
25 across outpatient sites of service, as well as payment policies that support value-based care and
26 encourage use of the most cost-effective care setting. The policy priority established by the Council
27 in previous reports addressing the site-of-service differential has been to ensure patient access to
28 services in the most clinically appropriate setting, depending on their needs and the severity of their
29 conditions. While an HOPD may be the appropriate setting for certain medically complex patients,
30 the migration of many services from physician offices to hospital-owned facilities is of significant
31 concern not only because of increased costs to the Medicare program, but also because it has
32 become increasingly difficult for practices in certain specialties to remain competitive or even
33 sustain operations because of declining payment rates and the increased costs to practices of
34 dealing with regulatory and administrative burdens. The Council continues to be concerned for
35 independent physician practices, and for Medicare patients who incur higher cost-sharing expenses
36 for outpatient services provided in hospital facilities whose care could have been safely provided in
37 lower-cost settings. The Council believes that policy proposals addressing the site-of-service
38 differential must be patient-centric and ensure adequate payment that supports the costs of
39 providing high-quality, high-value physician services.

40
41 Accordingly, the Council recommends reaffirming four existing policies that guide AMA advocacy
42 regarding the site-of-service differential: Policy H-240.993, which calls for equity of payment
43 between services provided by hospitals and similar services provided in physician offices; Policy
44 D-330.997, which supports defining Medicare services consistently across settings and
45 encouraging CMS to adopt payment policies that assist in leveling the playing field across all sites
46 of service; Policy H-400.957, which encourages CMS to expand the extent and amount of payment
47 for procedures performed in physician offices, to shift more procedures from the hospital to the
48 office setting, and to seek to have practice expense RVUs reflect the true cost of performing office
49 procedures; and Policy H-400.966, which promotes the compilation of accurate physician practice
50 cost data as the basis for informed and effective advocacy concerning Medicare physician payment.

1 Building on these policies, the Council recommends that the AMA support Medicare payment
2 policies for outpatient services that are site-neutral without lowering total Medicare payments. This
3 policy recommendation enables ongoing AMA advocacy in support of site-neutral payments while
4 at the same time seeking solutions that do not simply lower payments for services to amounts paid
5 to the least costly setting. The Council is mindful that there is the potential for physicians to be
6 adversely affected as Congress and the Administration promote site-neutrality based solely on cost
7 as a means of reining in health care spending.

8
9 The site-of-service differential impedes the provision of high-value care because it incentivizes
10 payment based on the location where a service is provided. Payment should be based on the service
11 itself, and not the location where it is provided. Accordingly, the Council recommends that the
12 AMA support Medicare payments for the same service routinely and safely provided in multiple
13 outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and
14 accurate data regarding the real costs of providing the service in each setting.

15
16 After extensive exploration of the “combined health care payment system” described in the second
17 resolve of Resolution 817-I-17, the Council concludes that the practice expense component of the
18 PFS is analogous to the facility fee paid under the OPPS, and that the valuation of the practice
19 expense component needs to be updated to accurately reflect the costs of running a practice. The
20 Council further believes that if physicians are paid a facility fee as called for in the second resolve,
21 that fee is likely to be smaller than the current one and might not make up for the probable
22 elimination of the practice expense differential in the current system. Rather than seeking the
23 statutory changes to implement a combined payment system that pays facility fees for both
24 hospital-owned and independent physician practices—which would be extremely challenging to
25 accomplish in a Congress hamstrung by partisanship and a trillion-dollar deficit—the Council
26 recommends urging CMS to update the data used to calculate the practice expense component of
27 the PFS. The Council believes that CMS should conduct a survey similar to the PPI Survey to
28 confirm the accuracy of practice expense data, given the many changes that have occurred since the
29 survey was administered in 2007 and 2008, and that this survey should be administered every five
30 years to ensure that timely data are used to inform PFS calculations. The Council believes that
31 CMS should collect data to ensure that all physician practice costs are captured. Examples of data
32 that must be collected by CMS include administrative and other costs that cannot be directly
33 attributed to a service, costs of managing the practice, costs of providing uncompensated care, costs
34 of navigating payer protocols and utilization management requirements, costs of purchasing,
35 managing and updating EHRs, and costs related to quality measures and improvements.

36
37 Advocating for regular ongoing collection of physician practice expense data that more accurately
38 reflect the costs of sustaining a practice is a viable option that could be impactful in the nearer term
39 although, under Medicare’s current system, PFS payments would be redistributed rather than
40 increased overall. The updated data could be used to help measure differences in the costs of
41 providing services in physician offices and hospital settings, and would inform future AMA
42 advocacy on broader payment reforms.

43
44 To address concerns regarding the methodology used for DSH and uncompensated care payments
45 to hospitals and the care provided by many physicians for which they are not fully compensated,
46 the Council recommends that the AMA encourage CMS to both: a) base DSH and uncompensated
47 care payments to hospitals on actual uncompensated care data; and b) study the costs to
48 independent physician practices of providing uncompensated care.

49
50 While the focus of this report is the site-of-service differential, the Council recognizes the need to
51 address broader physician payment issues. The Council further recognizes that achieving site-

neutral payments for outpatient procedures will require increases in Medicare payment for physician services so that physician practices can be sustained and patient choice of care setting is safeguarded. To help build the case for future Medicare payment reforms, the Council recommends that the AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 817-I-17, and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-240.993, which urges more aggressive implementation by the US Department of Health and Human Services of existing provisions in federal legislation calling for equity in payment between services provided by hospitals on an outpatient basis and similar services in physician offices. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy D-330.997, which encourages the Centers for Medicare & Medicaid Services (CMS) to define Medicare services consistently across settings and adopt payment methodology for hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) that will assist in leveling the playing field across all sites-of-service. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy H-400.957, which encourages CMS to expand the extent and amount of reimbursement for procedures performed in the physician office, to shift more procedures from the hospital to the office setting, which is more cost effective, and to seek to have practice expense relative value units reflect the true cost of performing office procedures. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-400.966, which directs the AMA to aggressively promote the compilation of accurate data on all components of physician practice costs, and the changes in such costs over time, as the basis for informed and effective advocacy concerning physician payment under Medicare. (Reaffirm HOD Policy)
5. That our AMA support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. (New HOD Policy)
6. That our AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting. (New HOD Policy)
7. That our AMA urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured. (New HOD Policy)

- 1 8. That our AMA encourage CMS to both: a) base disproportionate share hospital payments and
2 uncompensated care payments to hospitals on actual uncompensated care data; and b) study the
3 costs to independent physician practices of providing uncompensated care. (New HOD Policy)
4
- 5 9. That our AMA collect data and conduct research both: a) to document the role that physicians
6 have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of
7 the Medicare budget allocated to physician services that more accurately reflects practice costs
8 and changes in health care delivery. (Directive to Take Action)

Fiscal Note: \$100,000 to \$200,000

REFERENCES

- ¹ Avalere Health. Payment Differentials Across Outpatient Settings of Care. February 2016. Available at: http://go.avalere.com/acton/attachment/12909/f-0298/1/-/-/-/20160212%20-%20Payment%20Differentials%20Across%20Settings%20White%20Paper_FINAL.pdf.
- ² Ibid.
- ³ Congressional Budget Office. Estimate of the Budgetary Effects of HR 1314, the Bipartisan Budget Act of 2015, as reported by the House Committee on Rules on October 27, 2015. Available at: <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr1314.pdf>.
- ⁴ Centers for Medicare & Medicaid Services, Department of Health and Human Services. Medicare program; Revisions to payment policies under the physician fee schedule and other revisions to Part B for CY 2019; Medicare shared savings program requirements; Quality payment program; and Medicaid promoting interoperability program. *Federal Register*. July 27, 2018.
- ⁵ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2018. Medicare program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologicals for a Potential CMS Innovation Center Model. *Federal Register* (Vol. 83, No. 147) July 31, 2018.
- ⁶ Centers for Medicare & Medicaid Services, Department of Health and Human Services. Fact Sheet: CMS proposes Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System changes for 2019 (CMS-1695-P). June 25, 2018. Available at: <https://www.cms.gov/newsroom/fact-sheets/cms-proposes-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center>
- ⁷ Kane C. Updated data on physician practice arrangements: Physician ownership drops below 50 percent. AMA Policy Research Perspectives, 2017, and Updated data on physician practice arrangements: Inching toward hospital ownership. AMA Policy Research Perspectives, 2015. Available at: <https://www.ama-assn.org/sites/default/files/media-browser/public/health-policy/PRP-2016-physician-benchmark-survey.pdf>.
- ⁸ Kane C. Updated data on physician practice arrangements: Inching toward hospital ownership. AMA Policy Research Perspectives, 2015.
- ⁹ American Medical Association. Analysis of Medicare Trustees' reports and U.S. Bureau of Labor Statistics data. May 2018.
- ¹⁰ Ibid.
- ¹¹ Medicare Payment Advisory Commission. Medicare Fee-For-Service Payment Policy Across Sites of Care. Statement of Mark E. Miller, PhD before the House Committee on Energy and Commerce, Subcommittee on Health, May 21, 2014.
- ¹² 2017 AMA Prior Authorization Physician Survey. Available at: <https://www.ama-assn.org/sites/default/files/media-browser/public/arc/prior-auth-2017.pdf>.
- ¹³ Sinsky C et al. Allocation of physician time in ambulatory practice: a time and motion study in 4 specialties. *Ann Intern Med*. 2016;165:753-760. Available at: <http://annals.org/aim/fullarticle/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties>.
- ¹⁴ Casalino, LP et al. US Physician Practices Spend More Than \$15.4 Billion Annually to Report Quality Measures. *Health Affairs* 35, No. 3. 2016.
- ¹⁵ Medicare Payment Advisory Commission. A Data Book: Health care spending and the Medicare program. June 2018.
- ¹⁶ Ibid.
- ¹⁷ Gillis K. Physicians' Patient Mix – A Snapshot from the 2016 Benchmark Survey and Changes Associated with the ACA. AMA Policy Research Perspectives. 2017. <https://www.ama-assn.org/sites/default/files/media-browser/public/health-policy/PRP-2017-physician-benchmark-survey-patient-mix.pdf>.
- ¹⁸ Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy*. March 2012.
- ¹⁹ Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy*. March 2014.

²⁰ Wynn BO et al. Policy Options for Addressing Medicare Payment Differentials Across Ambulatory Settings. RAND Health (2011).

²¹ Office of Inspector General. Medicare and Beneficiaries Could Save Billions if CMS Reduces Hospital Outpatient Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates. April 2014.

²² Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2017. Medicare program; Revisions to payment policies under the physician fee schedule and other revisions to Part B for CY 2018; Medicare shared savings program requirements; and Medicare diabetes prevention program. Final rule. *Federal Register* 82, no. 219 (November 15).

²³ Ibid.

²⁴ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2018. Medicare program; Revisions to payment policies under the physician fee schedule and other revisions to Part B for CY 2019; Medicare shared savings program requirements; Quality payment program; and Medicaid promoting interoperability program. *Federal Register*. July 27, 2018.

²⁵ Ibid.

²⁶ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2018. Medicare program; Revisions to payment policies under the physician fee schedule and other revisions to Part B for CY 2019; Medicare shared savings program requirements; Quality payment program; and Medicaid promoting interoperability program. Proposed rule. *Federal Register*. July 27, 2018.

²⁷ Ibid.

²⁸ Public Law No: 113-93, the Protecting Access to Medicare Act of 2014. Available at: <https://www.congress.gov/bill/113th-congress/house-bill/4302>.

²⁹ McClellan M et al. Medicare Physician Payment Reform: Securing the Connection Between Value and Payment. The Brookings Institution. Health Policy Brief (January 2015).

³⁰ AMA letter to the Honorable Alex M. Azar, II, Secretary, US Department of Health and Human Services. June 21, 2018. Available at: <https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-6-21-Letter-to-Azar-HHS-Secy-re-PTAC-Models.pdf>.

JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE
AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-18)
Aligning Clinical and Financial Incentives for High-Value Care
(Reference Committee J)

EXECUTIVE SUMMARY

The Council on Medical Service and the Council on Science and Public Health present this joint report to expand upon prior studies of access to and coverage for preventive services and other high-value health care services. A factor mitigating patient concerns about the cost of preventive care is the Affordable Care Act's (ACA) requirement that health plans cover select preventive services without any patient cost-sharing (zero-dollar). The ACA requirement of coverage for select preventive services without cost-sharing has been a popular and successful step in promoting access to preventive care, but more could and should be done to facilitate and incentivize high-value care. Value-Based Insurance Design (VBID) is a potential partial solution consistent with long-standing American Medical Association (AMA) policy. This report highlights the utilization of preventive services under ACA's mandated zero-dollar coverage, key challenges posed by the ACA mandated coverage, legal and regulatory obstacles, examples of how VBID has been used successfully to better align incentives for high-value care, and opportunities for expanded use of VBID.

The Councils recommend reaffirmation of existing AMA policy, as well as new policy to promote alignment of clinical and financial incentives for high-value care. Building on AMA policy regarding VBID, the Councils recommend that the AMA support: VBID plans designed in accordance with the tenets of "clinical nuance;" implementing innovative VBID programs in Medicare Advantage plans; and legislative and regulatory flexibility to accommodate VBID that (a) preserves health plan coverage without patient cost-sharing for evidence-based preventive services, and (b) allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services. To enhance the effectiveness of VBID, the Councils recommend that the AMA support initiatives to align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform. Additionally, recognizing the critical role that physicians of all specialties should play in shaping effective VBID programs, the Councils recommend that the AMA encourage national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services.

In addition, the Councils recommend three ways to protect and improve access to zero-dollar preventive care. First, the Councils recommend that the AMA continue to support requiring private health plans to provide coverage for evidence-based preventive services without imposing cost-sharing on patients. Second, the Councils recommend that the AMA develop coding guidance tools to help providers appropriately bill for zero-dollar preventive interventions and promote common understanding regarding what will be covered at given cost-sharing levels. Finally, the Councils recommend that the AMA develop physician educational tools that prepare physicians for conversations with their patients about the scope of preventive services provided without cost-sharing and instances where and when preventive services may result in financial obligations for the patient.

JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE
AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CMS/CSAPH Joint Report I-18

Subject: Aligning Clinical and Financial Incentives for High-Value Care

Presented by: James G. Hinsdale, MD, Chair, Council on Medical Service
Robyn F. Chatman, MD, MPH, Chair, Council on Science and Public Health

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

1 The Council on Medical Service and the Council on Science and Public Health present this joint
2 report to expand upon prior studies of access to and coverage for preventive services and other
3 high-value health care services. The Councils decided to pursue this report in light of: (a) the
4 confusion among provider, patient, and payer communities in paying for preventive services; and
5 (b) a common goal of improving affordable access to “high-value” services (as described below).

6
7 One factor mitigating patient concerns about the cost of preventive care is the Affordable Care
8 Act’s (ACA) requirement that health plans cover select preventive services without any patient
9 cost-sharing (zero-dollar). The Councils previously considered preventive services in the Council
10 on Medical Service and Council on Science and Public Health Joint Report at the 2017 Annual
11 Meeting, “Value of Preventive Services.” As detailed in the A-17 report, the ACA required all
12 private, non-grandfathered health insurance plans to provide zero-dollar coverage for the
13 preventive services recommended by four expert organizations: the U.S. Preventive Services Task
14 Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Women’s
15 Preventive Services Initiative, and Bright Futures. The report also described the varied methods
16 used by those four organizations for developing preventive service guidelines. The report
17 established Policy H-460.894, which encouraged those organizations to develop their
18 recommendations with transparency, clarity and specificity. Given the significant challenges that
19 have arisen as the health care industry strives to provide zero-dollar coverage for the expert
20 organizations’ recommendations, further study was warranted to explore additional policy options
21 for promoting access to preventive interventions.

22
23 The ACA requirement of coverage for select preventive services without cost-sharing has been a
24 popular and successful step in promoting access to preventive care, but more could and should be
25 done to facilitate and incentivize high-value care. Value-Based Insurance Design (VBID) is a
26 potential partial solution consistent with long-standing American Medical Association (AMA)
27 policy. This report highlights the utilization of preventive services under ACA’s mandated zero-
28 dollar coverage, key challenges posed by the ACA-mandated coverage, legal and regulatory
29 obstacles, examples of how VBID has been used successfully to better align incentives for high-
30 value care, and opportunities for expanded use of VBID. Finally, this report makes several policy
31 recommendations.

BACKGROUND

Health care affordability is determined not just by the cost of insurance coverage (e.g., the premium), but also by the amount of cost-sharing required (e.g., deductibles, co-payments, and coinsurance). The median level of liquid assets among nonelderly American households was below the cost-sharing requirements of many health insurance plans and significantly below the maximum out-of-pocket limits allowed for private insurance in 2016,¹ indicating potential challenges, especially for families with low incomes and/or significant medical bills.

Concerns about the cost of care have caused some Americans to delay or skip necessary health care. In a recent poll (n=1,302), more than a third of Americans indicated that they made health care decisions in the past year based on costs, including 44 percent who reported not going to the doctor when they were sick or injured, 40 percent who reported going without a routine physical or other preventive care, 40 percent who reported skipping a medical test or treatment, and 32 percent who reported either not filling a prescription or taking less than the prescribed dose.²

Patients and physicians alike encounter a dilemma when an ACA-designated preventive service that is provided without patient cost-sharing identifies early stage illness, and subsequent medical interventions can impose significant out-of-pocket costs on patients. At the same time, such interventions can be characterized as “high-value” care -- they potentially minimize human suffering, maximize the opportunity for beneficial medical intervention, save the health care system the costs of treating advanced disease, and save society the costs of losing productive individuals. Inherently, “high-value” care is subjective and challenging to define -- the same service can be life-saving for one patient and over-treatment for another patient. Accordingly, rather than restricting “high-value” care with one specific definition, experts explain that the key is for the health care system to embrace the concept that not all care provides equal value.³ It is not necessary for all to agree which services must always be considered “high-value.” Instead, simply building consensus around some selected services and aligning payer, provider, and patient incentives around those services is beneficial. This report explores opportunities to identify high-value care, some of the ways in which incentives are currently misaligned, methods already being used successfully to promote more optimal alignment, and policy recommendations to advance progress in this space.

SUCSESSES AND CHALLENGES IN IMPLEMENTING THE ACA PREVENTIVE SERVICES BENEFITS

The ACA’s mandated zero-dollar coverage for select preventive services enjoys strong bipartisan support. A recent poll found that the ACA provision eliminating out-of-pocket costs for certain preventive services was favored by 83 percent of Americans (n=1,202) surveyed, including 89 percent of Democrats, 83 percent of Independents, and 77 percent of Republicans.⁴ Prior to the ACA it was estimated that Americans received only about half of the preventive services that are recommended.⁵ While it is estimated that 71 million Americans received expanded coverage of one or more preventive services in 2011 and 2012 as a result of the ACA, studies examining the utilization of preventive services over a limited time horizon post-ACA have found mixed results.⁶ For example, among adults (age 18 to 64), the ACA was associated with an increase in physicians’ provision of preventive cardiovascular services, including the use of diabetes screening, tobacco use screening, hypertension screening, and aspirin therapy in men.⁷ It was also associated with increases in up-to-date rates of routine checkups and flu vaccinations.⁸ However, changes in blood pressure checks, cholesterol checks, and certain cancer screenings were not associated with the ACA.⁹ A review of studies focused on the ACA’s impact on cancer screening found mixed results. While studies indicated that some cancer screening (pap smear test, mammography, and colorectal

cancer screening) did not increase post-ACA implementation,¹⁰ other studies found statistically significant increases in earlier diagnosis of certain cancers associated with Medicaid expansion and parents' ability to maintain insurance coverage for their children up to age 26.¹¹ Multiple studies also have found evidence of substantial positive impacts among low-socioeconomic status groups and groups subject to high cost-sharing prior to the ACA.¹² While such initial studies are informative, additional research across longer time horizons is necessary to fully understand the impact of the ACA benefit that removed cost-sharing for select preventive services on utilization and health outcomes.

Similarly, even with cost-sharing barriers removed, additional barriers to provision of preventive services still exist and may include inconsistently applied definitions of key terminology, limited knowledge of preventive service guidelines, and limited time with patients. For example, the classification of a service as "screening," "diagnostic," or "therapeutic" can be unclear. Some of this confusion can be traced back to legal definitions of "preventive care." As explored in greater detail below, preventive care takes on legal significance in the context of health savings accounts (HSAs) associated with eligible high deductible health plans (HDHPs), as these plans generally cannot cover medical items or services until the deductible is met. A preventive care safe harbor via Section 223(c)(2)(C) of the Internal Revenue Code provides an exception to this rule for certain preventive care.¹³ However, preventive care is not clearly defined by law.¹⁴ Given the significant inconsistency and confusion that persists when referring to preventive services, this report will avoid use of the commonly confused terms. Additionally, patients are not familiar with the preventive services that are available to them without cost-sharing.¹⁵ Three and half years after the ACA took effect, less than half the population (43 percent) reported being aware that the ACA eliminated out-of-pocket expenses for preventive services.¹⁶

Underinsurance & Cost-Related Non-Adherence (CRN): While increasing access to health insurance has been beneficial to patients, it is nevertheless critical to recognize the challenges posed by underinsurance and CRN. Rates of underinsurance – defined as out-of-pocket costs that are high relative to income – have risen, with 13 percent of adults underinsured in 2005,¹⁷ and 28 percent of adults underinsured in 2016.¹⁸ Even when a service is covered by a health plan, patients may incur significant costs in the form of co-payments, coinsurance, and/or large medical bills that they must pay before meeting their deductible. Such costs have been shown to cause people, especially those in low-income and vulnerable populations, to forgo not only unnecessary but also necessary care.¹⁹ In fact, as little as a \$10 rise in co-payments has been associated with a significant decline in outpatient visits and a concurrent increase in hospital utilization among an elderly population.²⁰ Similarly, CRN refers to a state in which patients are unable to pursue recommended medical care due to financial barriers.²¹ Sub-optimal use of evidence-based medical services can lead to negative clinical outcomes, increased disparities, and in some cases, higher aggregate costs.²² CRN has been identified across the entire continuum of clinical care -- physician visits, preventive screenings, prescription drugs, etc. -- and it is especially problematic for vulnerable populations, such as those with multiple chronic conditions, and for socioeconomically and racially disparate populations.²³ For example, greater out-of-pocket costs for medication to treat certain chronic conditions has been found to reduce initiation and adherence, lower the likelihood of achieving desired health outcomes, and sometimes, increase utilization of acute care services.²⁴ At the same time, studies have demonstrated that reducing or eliminating cost-sharing leads to improvements in medication adherence²⁵ and reductions in socioeconomic and racial disparities.²⁶

Both underinsurance and CRN can be exacerbated in the context of the rising prevalence of HDHPs. HDHPs are insurance plans associated with lower premiums, higher deductibles and greater cost-sharing requirements as compared with traditional health plans.²⁷ An HDHP is frequently combined with a personal health account, a combination referred to as a "consumer-

directed health plan.”²⁸ A personal health account can either be a HSA or health reimbursement arrangement (also known as a health reimbursement account or HRA).²⁹ HSAs are tax-free accounts used to pay for qualified medical expenses, and they must be paired with an HDHP.³⁰ HRAs are employer-funded accounts used to reimburse employees for qualified medical expenses. HRAs need not be paired with an HDHP.³¹ While employees can keep unspent money in an HSA and accumulate savings from year to year, unspent HRA funds are forfeited to the employer at the end of a calendar or benefit year. Enrollment in HDHPs by individuals younger than 65 years who have private health insurance has increased sharply – from 25.3 percent of the population studied in 2010, to 47.0 percent in the first three months of 2018.³² Moreover, the size of deductibles has increased dramatically. In 2003, only one percent of adults enrolled in a private plan had a deductible of \$3,000 or more, but by 2016, that percentage rose to 13.³³ HDHPs appear to reduce health care costs by decreasing the use of both appropriate care (such as recommended cancer screenings) and inappropriate care (such as low-severity emergency department visits).³⁴ Greater consumer cost-sharing is frequently used as a lever to minimize the growth of health insurance premiums.³⁵ Studies have found that families who have members with chronic disease and who are enrolled in HDHPs are more likely to go without care due to cost and/or face substantial financial burdens, such as trouble paying bills, than families enrolled in traditional plans.³⁶ Another study found that enrollment in an HDHP, combined with an HRA or HSA, led to significant increases in out-of-pocket spending, with more than half of the enrollees with lower-incomes and more than one-third of the enrollees with chronic conditions facing “excessive financial burden.”³⁷

At the same time, patients’ deductibles are only a fraction of their total out-of-pocket spending. Once coinsurance and co-payments are also factored in, a recent study of individuals enrolled in large employer health plans (n=between 1.05 and 15.3 million per year) found that total out-of-pocket spending rose by 54 percent between 2006 and 2016, from an average of \$525 in 2006 to an average of \$808 in 2016.³⁸ Moreover, individuals in the top 15 percent of health spenders (who account for 79 percent of total health spending), had out-of-pocket costs averaging \$2,837 in 2016.³⁹ Exacerbating this challenge is the fact that while out-of-pocket health care costs have been rising in recent years, wages have been relatively stagnant.⁴⁰

In light of these significant financial concerns, it is especially important that patients understand the availability of certain preventive services without any cost-sharing. Moreover, as described later in this report, efforts are underway to remove legislative and regulatory barriers to innovative insurance plan designs that could better align incentives around high-value services.

Coding, Billing, and Payment Challenges: The mismatch between the clinical intent of expert organizations’ evidence-based recommendations and the ACA’s mandated insurance coverage of recommended preventive services has added complexity to billing and payment practices, sometimes resulting in unexpected, and perhaps unintended, patient cost-sharing. Some specific challenges include:

- When a patient receives a designated preventive service, a private health insurance plan may still impose cost-sharing if: (1) the provider bills the services and the visit separately; or (2) the preventive service was not the primary purpose of the visit. Moreover, guidance is not clear regarding who determines what constitutes the primary purpose of a visit.
- If the expert organization does not specify the “frequency, method, treatment or setting” for a service, private health plans may use “reasonable medical management techniques” and “the relevant evidence base” to shape coverage/coverage limitations.⁴¹
- A private health plan may impose cost-sharing for treatment that is needed subsequent to a designated preventive service.

- Certain USPSTF recommendations apply only to “average risk” or certain “high-risk” populations. As a result, only those patients are entitled to receive the preventive service without cost-sharing. Federal guidance has clarified that the designation of “high-risk” is left to the attending provider. However, it can be unclear how a health plan is to know when a service was provided to a patient who is entitled to the service at no cost-share. Current Procedural Terminology (CPT) modifier 33 can be used when billing for ACA-designated preventive services. The addition of modifier 33 communicates to a commercial payer that a given service was provided as an ACA preventive service. While modifier 33 does not apply to Medicare patients, the CPT modifier was developed to indicate that a colonoscopy that was scheduled as a screening was converted into a diagnostic or therapeutic procedure. Nevertheless, review of the literature indicates that confusion and inconsistency persist among providers and payers in coding and paying these claims and may be contributing to the misaligned expectations observed throughout the health care industry.
- It is unclear what state and federal systems are in place to monitor and ensure enforcement of the ACA requirements. Even if individuals know they are entitled to receive certain preventive services without cost-sharing, they may not know how to seek redress if they are charged for these services.

EXPANDING ACCESS TO HIGH-VALUE SERVICES

In addition to the implementation challenges described above, patients and physicians find themselves challenged when findings from a zero-dollar preventive service lead to very expensive subsequent medical care. Furthermore, preventive interventions not designated by ACA that are deployed to prevent significant morbidity may be associated with significant patient cost-sharing. Accordingly, health plan financial incentives for patients do not always support the goal of proactively managing medical risk and preventing serious morbidity.

The juxtaposition of legitimate patient financial concerns and the high value of many preventive interventions highlights significant misalignment of clinical and financial incentives that pervades our health care system. While designation by expert organizations of preventive services to be provided without cost-sharing is a start, an initial designated service may be insufficient to achieve broader clinical goals. Instead, subsequent necessary steps can require significant financial outlays by the patient. In these cases, the clinical impact of a recommended service may not fulfill its potential if patients are unable to follow through on their physicians’ guidance due to financial barriers. Several of the current system’s misaligned incentives are illustrated below.

Misaligned Incentives – More Invasive Services: For clinical and economic reasons, it can make sense to promote less expensive, less-invasive screening as a first step, and progress to invasive tests when medically indicated. However, the current system sometimes incentivizes the opposite, when lower cost-sharing levels sometimes apply to more expensive, more invasive procedures. For example, consider a primary care physician who wants to follow the USPSTF’s recommendation⁴² and encourage a 55 year-old patient to receive colorectal cancer screening. The physician discusses the recommendation with the patient, and the patient refuses to receive a colonoscopy (citing fear of the bowel preparation, fear of anesthesia, etc.). The physician and the patient agree that for this patient, Cologuard®, a non-invasive stool test, is an appropriate initial method of screening. The Cologuard® is provided to the patient without cost-sharing. However, when the results of the Cologuard® are positive, the physician advises that a colonoscopy is necessary to complete the colorectal cancer screening. While this colonoscopy would have been provided without cost-sharing had it been chosen as the first screening method, a colonoscopy that follows a positive stool test sometimes results in imposition of a significant cost-sharing burden on the patient.⁴³ The

1 potential cost burden, in addition to the patient's already established concerns regarding
2 colonoscopy, may dissuade the patient from completing the screening process.

3
4 Misaligned Incentives – Individual Risk Factors: In striving to prevent advanced disease,
5 physicians often identify individual risk factors that subject their patients to a greater than average
6 risk of various diseases. Some may be at higher risk for breast cancer, and others at higher risk for
7 diabetes, and some may be at heightened risk for multiple serious diseases. Ideally, financial
8 incentives would encourage patients to receive high-value services that are most likely to help them
9 as individuals, and prioritize those over services that are less aligned with their individual risk
10 profile. However, under our current health care system, individuals at heightened risk can be
11 precluded from cost-sharing incentives for some high-value services.

12
13 For example, the USPSTF recommends breast cancer screening mammography for asymptomatic
14 women who are not at high risk for breast cancer.⁴⁴ Women at high risk include those who have
15 preexisting breast cancer, a previously diagnosed high risk breast lesion, a known underlying
16 genetic mutation (such as a *BRCA1* or *BRCA2* gene mutation or other familial breast cancer
17 syndrome), or a history of chest radiation at a young age.⁴⁵ A biannual mammogram will be free of
18 cost-sharing to a woman at average risk. However, women who are at heightened risk, who need
19 the test most frequently, and for whom the test may more often be positive, must share in often
20 significant costs. While screening mammography is not provided without cost-sharing to patients at
21 increased risk for breast cancer, the USPSTF recommends that “for women who are at increased
22 risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to
23 prescribe risk-reducing medications, such as tamoxifen or raloxifene.”⁴⁶ Thus, a patient at
24 increased risk for breast cancer may receive risk-reducing medications without cost-sharing, but
25 must share in the costs of mammography.

26
27 Misaligned Incentives – Detection vs. Monitoring, Treatment, and Continuing Prevention: When
28 physicians choose to screen their patients for a given disease, their goal is not to simply provide a
29 diagnosis, but rather to help their patients manage risk and promote long-term health. Under our
30 current health care system, risk can be identified without cost-sharing, but the management of that
31 risk can burden patients with significant financial costs.

32
33 For example, the USPSTF recommends that fair skinned young adults, adolescents, children, and
34 parents of young children receive counseling regarding minimizing exposure to ultraviolet
35 radiation to reduce their risk of skin cancer.⁴⁷ Counseling would be covered without patient cost-
36 sharing. However, consider a situation where the counseling primary care physician refers a fair
37 skinned young adult to a dermatologist for a visual skin examination. A visual skin exam by a
38 dermatologist may help prevent or detect skin cancer. However, the USPSTF concluded that the
39 current evidence is insufficient to assess the balance of benefits and harms of visual skin
40 examinations by clinicians and whether such exams reduce skin cancer-related morbidity and
41 mortality. A visual skin exam conducted by a dermatologist would likely result in patient cost-
42 sharing, which may be significant, especially if the patient has not yet met their plan deductible. If
43 the dermatologist decides to biopsy a mole, the procedure and pathology may incur significant
44 cost-sharing for the patient. If the biopsy indicates early stage malignancy, removing the mole may
45 prevent serious morbidity, but it may result in substantial additional cost-sharing. Finally, to ensure
46 that subsequent disease is prevented and/or eradicated before it becomes invasive, a treating
47 physician would want to incentivize this patient to practice on-going preventive habits such as
48 purchasing and utilizing sunscreen and committing to follow-up visits with a dermatologist.
49 However, since the purchase of sunscreen and dermatologist visits are outside the scope of the
50 USPSTF, these valuable items and services will impose significant lifetime costs on the patient.

One can anticipate how similar misaligned incentives pervade our current system, in attempts to prevent morbidity from cancer, mental illness, and many other chronic diseases. For example, the USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese.⁴⁸ Moreover, the USPSTF encourages clinicians to offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.⁴⁹ However, an array of evidence-based services to prevent onset of diabetes (e.g., community health worker diabetes prevention programs (DPPs)⁵⁰ and combined diet and physical activity promotion programs⁵¹) and/or to prevent disease advancement and morbidity (e.g., insulin to keep blood glucose well-managed, regular eye and foot examinations, etc.⁵²) are outside the scope of the ACA's mandated zero-dollar benefit and subject to significant patient cost-sharing. While studies have found savings of approximately \$1,300 for every Medicare Advantage (MA) patient who completed a diabetes education program, insured patients may, due to cost-sharing, expend hundreds of dollars to participate.⁵³ Consider this in the context of the finding, described above, that even a \$10 increase in co-payments has been associated with a significant decline in outpatient visits and a concurrent increase in hospital utilization among an elderly population.⁵⁴ Recognizing the value of prevention programs, some payers interpret the USPSTF recommendation broadly and/or develop a commitment to covering DPPs as an evidence-based preventive program that mitigates rising risk. Such payers, including commercial health plans, as well as some Medicare and Medicaid programs, offer DPPs as a preventive service without patient cost-sharing.

An additional facet of misaligned incentives arises when patients find themselves "penalized in the form of high cost-sharing simply because of their biology."⁵⁵ For example, consider patients with major depressive disorder. Some patients may respond well to generic medications that are subject to the lowest level of cost-sharing. Other patients, though, may not achieve the desired clinical outcome with the less expensive medication, and to prevent disease progression, those patients may require medication that is only available at a higher level of cost-sharing. This higher level of cost-sharing, however, can disincentivize medication initiation and adherence.

Consistent with long-standing AMA policy that promotes testing individuals and population groups only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified, high-value services clearly span a broad spectrum of care.⁵⁶ Great value can be achieved by preventing adverse consequences that could arise from early stage or more advanced disease.⁵⁷ The challenges in effectively describing "value" to optimally promote it through regulations contribute to the misaligned incentives observable across the spectrum of care.

VALUE-BASED INSURANCE DESIGN AS A METHOD FOR ALIGNING INCENTIVES AROUND HIGH-VALUE SERVICES

To ensure that people get the medical care they need, they must be able to afford treatment associated with identified risk factors and diagnosed disease. More Americans are afraid of the costs associated with a serious illness than of the illness itself.⁵⁸ Accordingly, while zero-dollar screenings are a significant advance, health insurance must also provide access to affordable on-going care for patients at higher risk for serious disease and/or advancement of existing disease.

Aligning Incentives Across Supply and Demand Sides: As outlined in Council on Medical Service (CMS) Report 9-A-16 and CMS Report 10-A-17 and consistent with Policy H-385.913, the AMA recognizes the continuing importance of alternative payment models (APMs) and the roles physicians should play in developing APMs. Provider-facing initiatives such as payment reform (including APMs), health information technology, and practice redesign operate on the supply side of the health care economic market.⁵⁹ On the supply side, some financial incentives are aligned

between payers and providers around quality metrics. The other critical piece of the health care economic model, of course, is the consumer demand side, which includes health care literacy programs, shared decision making, price transparency, and benefit design.⁶⁰ With benefit design, financial incentives are created between patients and third-party payers, and these incentives impact what care patients will pursue. While both payment reform and benefit design may theoretically be working toward the same goal of “quality” health care, unless those supply side and demand side incentives are actually, intentionally aligned, it can be excessively and unfairly challenging for patients, providers, and payers to achieve their shared goal of quality. For example, a quality metric for primary care physicians may be the extent to which their patients’ blood glucose is within an acceptable range. To help their patients manage uncontrolled blood glucose, primary care physicians may wish to refer their patients to an endocrinologist and/or to a DPP. However, if the patients’ insurance benefits impose significant cost-sharing for specialist visits and/or for DPP enrollment, the patients may not have the financial means to follow through with their primary care physicians’ advice. As a result of these misaligned incentives, the system may face: (a) primary care physicians who cannot meet their quality metrics due to patient non-compliance; (b) patients who forgo high-value care due to financial barriers and subsequently become sicker; (c) employers that lose productivity due to employee illness; and (d) payers that ultimately pay more money to care for sicker patients. Clearly, this is an avoidable result that benefits no one. Accordingly, in considering actions that can be taken to improve access to high-value care, it is imperative to look at both the supply side (payment reform) and the demand side (benefit design) and ensure that both systems are designed to support each other and incentivize consistent behavior across the health care economy. Moreover, services established as quality metrics (eg, by the National Quality Forum or the National Committee for Quality Assurance) can be strong examples of “high-value” services around which patient, provider, and payer financial incentives could be aligned.

Value-Based Insurance Design (VBID): Health plans can apply VBID principles to design benefits that reduce financial barriers to and incentivize use of high-value care. VBID was designated as a federal policy priority in the ACA,⁶¹ and the AMA has long supported VBID, with the Council on Medical Service issuing a report at the 2013 Annual Meeting that set forth principles to guide implementation of VBID initiatives.⁶² As explained in CMS Report 2-A-13, traditional health insurance benefit designs use patient cost-sharing primarily as a way to control health care costs. In contrast, VBID uses cost-sharing as a tool to encourage the use of specific health care services based on “value,” which is defined as the clinical benefit gained for the money spent.⁶³ While traditional benefit designs apply a standard set of cost-sharing requirements to all services and all patients, VBID determines coverage and cost-sharing rules based on an assessment of the clinical value of individual health care treatments or services.⁶⁴ VBID plans vary patients’ out-of-pocket costs, such as co-payments, coinsurance, and deductibles, based on the value of specific services. Specifically, VBID plans are designed in accordance with the tenets of “clinical nuance,” recognizing that (1) medical services may differ in the amount of health produced; and (2) the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided.⁶⁵

Applying “clinical nuance,” health plans can address some of the misaligned incentives. Returning to the example of a patient with uncontrolled blood glucose introduced above, to prevent complications associated with diabetes, and to incentivize adherence to evidence-based measures, a VBID plan may choose to reduce the cost-sharing associated with critical diabetes items or services such as insulin therapy or vision exams. VBID principles can be applied to prescription drug formularies according to a “reward the good soldier” or “step edit with co-pay relief” strategy.⁶⁶ Under such models, if a patient tries a first-line lower-cost therapy, and that therapy proves to be ineffective in achieving the desired clinical outcome for that patient, the patient would be able to

access an otherwise more expensive therapy at a lower cost-sharing level. A recent systematic literature review found that using a VBID approach to decreasing cost-sharing for targeted prescription drug classes was significantly associated with improved medication adherence, and limited evidence also indicated improvement in clinical outcomes and quality.⁶⁷ Moreover, there was no effect on total health care spending, suggesting that the increased spending on prescription medication was offset by decreased spending on other medical items or services.⁶⁸

VBID Program Expansion: Currently, hundreds of private self-insured employers, public organizations, nonprofits and insurance plans have designed and tested VBID programs, and VBID experts believe the design method has reached a “tipping point.”⁶⁹ The recently enacted Bipartisan Budget Act of 2018 incorporates the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017 and requires expansion of the Medicare Advantage Value-Based Insurance Design Model to all 50 states by no later than January 1, 2020.⁷⁰ The model allows MA plans the flexibility to reduce cost-sharing or offer supplemental benefits to enrollees with specified chronic conditions, focusing on the services that are of highest clinical value to them.

In addition to the MA VBID model, the federal government continues to embrace VBID by supporting expanded application of VBID principles by public and private payers. The Centers for Medicare & Medicaid Services MA Final Rule for contract year 2019 provides greater flexibility around the MA uniformity requirement to allow for the implementation of VBID principles throughout the MA program.⁷¹ This flexibility gives MA plans new tools to improve care and outcomes for enrollees by allowing MA plans to reduce cost-sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer different deductibles for beneficiaries who meet specific medical criteria.⁷² TRICARE is also working to improve health outcomes and enhance the experience of care for US Armed Forces military personnel, military retirees, and their dependents through VBID pilot programs. The 2017 National Defense Authorization Act (NDAA) commissioned a pilot program to demonstrate and test the feasibility of incorporating VBID into the TRICARE program, and the 2018 NDAA further incorporates VBID principles into the TRICARE Pharmacy Benefits Program.⁷³

Connecticut implemented a collectively bargained state-based VBID program for its state employees that is one of the first to apply VBID to not only prescription drugs, but to reduce cost-sharing for enrollees across the spectrum of care, including medical services for chronic diseases.⁷⁴ Moreover, this Connecticut program both removed financial barriers to services known to be clinically valuable and instituted requirements that enrollees obtain certain preventive services, with the goal of encouraging enrollees to participate in their preventive and chronic disease care. Connecticut implemented its program in 2011, and early results were published in 2016. While more research is needed to inform optimal design of VBID plans, early evidence is encouraging. Highlights of the Connecticut model include:

- Enrollees overwhelmingly chose to enter and stay in the VBID plan. While participation in the plan was voluntary, first year enrollment exceeded 98 percent and about 98 percent of the enrollees were deemed compliant with the plan requirements at the end of each of the first two years of the program.
- There were significant gains in preventive office visits and nearly all of the targeted preventive screenings in both the first and second years of the program.
- The total number of emergency department visits without a resulting hospital admission decreased significantly in both the first and second years of the program.
- For the chronic diseases studied, there were significant increases in physician office visits and medication possession ratios, relative to a comparison group.

Connecticut's experience suggests that payers considering VBID programs should proactively weigh the benefits of potentially improved health and productivity against the potential for higher costs that can be associated with increased use of high-value services.⁷⁵ Connecticut's program also highlights critically intertwined drivers of health care spending: (a) the majority of overall health care spending is dedicated to chronic disease; (b) most chronic diseases have evidence-based quality metrics; (c) evidence indicates suboptimal performance on those quality metrics; and (d) patient out-of-pocket spending is a significant contributor to underutilization of care. Other payers could replicate the Connecticut plan's focus on chronic conditions.⁷⁶

Centers for Disease Control and Prevention (CDC) 6|18 Initiative: The CDC's 6|18 initiative is another example of efforts underway to align purchasers, payers, and providers to improve health and control costs through increased coverage of evidence-based preventive interventions. The initiative focuses on preventing chronic and infectious disease by increasing coverage, access, utilization, and quality. The CDC is specifically targeting six common and costly health conditions – tobacco use, high blood pressure, health care-associated infections, asthma, unintended pregnancies, and diabetes.⁷⁷ Eighteen evidence-based interventions have been identified as a starting point of discussions with purchasers, payers, and providers.⁷⁸ The CDC is providing technical assistance to state Medicaid programs and public health departments to implement the prioritized interventions and to private payers to help them identify interventions that will help their beneficiaries.

Barriers to VBID Expansion: Obstacles will likely prevent optimal customization of VBID plans in the short-term, as there are significant administrative burdens associated with identifying which services are highest value for which plan beneficiaries. However, plans should be encouraged to experiment with innovative plan designs that implement discrete elements of VBID, and legislative and regulatory changes would facilitate this goal.

HSA-HDHPs are among the fastest-growing plan types in the United States, and while current Internal Revenue Service (IRS) regulations permit a "safe harbor" that allows for coverage of specified preventive services prior to satisfaction of the plan deductible, that safe harbor is significantly limited.⁷⁹ IRS regulations state that clinical services meant to treat "an existing illness, injury, or condition" cannot be included in pre-deductible coverage.⁸⁰ Thus, even if a health plan would like to develop an HSA-HDHP according to VBID principles, many essential clinical services used to manage chronic illness could not be covered in HSA-HDHPs before the entire deductible is met. However, when HSA-HDHP enrollees with existing conditions or risk factors are required to pay out-of-pocket for necessary services prior to meeting the plan deductible, the results can be lower utilization of care, potentially resulting in poorer health outcomes and higher costs.⁸¹

VBID experts refer to a natural evolution from the current HSA-HDHP system to a "High-Value Health Plan" (HVHP) system that grants insurers the flexibility to provide pre-deductible coverage for high-value services across the spectrum of clinical care.⁸² Legislative and regulatory barriers should not prevent this evolution, and bipartisan efforts are underway to remove these barriers. The bipartisan, bicameral "Chronic Disease Management Act of 2018" (S.2410, H.R.4978) was introduced in February 2018, and if enacted, would permit HDHPs "to provide chronic disease prevention services to plan enrollees prior to satisfying their plan deductible."⁸³ VBID experts explain that this strategy would lower US health care expenditures and provide millions of Americans expanded plan options that better meet their clinical needs and contribute to their financial well-being.⁸⁴ America's Health Insurance Plans has also explained that this approach would improve the value of HSA-qualified plans for consumers and improve access to care for chronic conditions.⁸⁵

1 While VBID is not a panacea to singlehandedly expand access to and utilization of all critical high-
2 value preventive interventions, it is a powerful tool. Other tools include literacy programs, health-
3 information technology interventions and alternative clinician payment models,⁸⁶ all of which are
4 consistent with AMA policy.

5 6 AMA POLICY

7
8 The AMA has extensive policy supporting evidence-based preventive services. Policy H-165.840
9 advocates for evidence-based prevention to be covered for all patients. Policy H-425.997 supports
10 coverage for evidence-based, cost-effective preventive services; Policy H-165.848 supports a
11 requirement that preventive health care be included as minimal coverage and Policy H-390.849
12 supports providing patients with information and incentives to encourage appropriate utilization of
13 preventive services. Regarding alignment of covered benefits, Policy H-425.994 emphasizes the
14 importance of only pursuing testing in patients when adequate treatment and follow-up can be
15 arranged for identified abnormal conditions and risk factors and Policy D-385.966 encourages
16 reasonable payment for mandated benefits in health insurance policies. Additionally, Policy
17 H-165.846 sets forth principles to guide the evaluation of the adequacy of health insurance
18 coverage options.

19
20 Moreover, Policy H-425.986 encourages communication and cooperation among physicians and
21 public health agencies to address challenges in preventive medicine. Policies D-330.967 and
22 H-425.987 support continued collaboration with national medical specialty societies and interest
23 groups to encourage coverage for evidence-based recommendations regarding preventive services,
24 especially for populations at high risk for a given condition. Policy H-440.875 emphasizes the
25 AMA's commitment to collaborating to assure access to ACIP-recommended vaccines. Policy
26 H-425.988 supports continuing collaboration with the federal government, specialty societies, and
27 others, to develop guidelines for, and effective means of delivery of, clinical preventive services.
28 Similarly, Policy D-330.935 states that the AMA will collaborate with relevant stakeholders,
29 including appropriate medical specialty societies, to actively promote to the public and the
30 profession the value of Medicare-covered preventive services and support the expansion of first-
31 dollar coverage for a preventive visit and required tests anytime within the first year of enrollment
32 in Medicare Part B. Policy H-425.992 advocates for revision of current Medicare guidelines to
33 include coverage of appropriate preventive medical services.

34
35 Various AMA policies call for coverage with no cost-sharing, including: Policy H-185.969
36 regarding immunizations, Policy D-330.935 regarding Medicare preventive service benefits, and
37 Policy H-290.972 for preventive coverage for HSA holders in the Medicaid program. Policy
38 D-425.992 expresses concern regarding the effect that USPSTF recommendations can have on
39 limiting access to preventive care for Americans (e.g., regarding access to screening
40 mammography and prostate specific antigen screening) and encourages the USPSTF to implement
41 procedures that allow for meaningful input on recommendation development from specialists and
42 stakeholders in the topic area under study.

43
44 Finally, AMA policy strongly supports APMs, VBID, and innovative insurance design. Policy
45 H-385.913 sets forth principles to guide physician-focused APMs. Policy H-450.938 has principles
46 to guide physician value-based decision-making and emphasizes that physicians should seek
47 opportunities to integrate prevention services into office visits. Policy H-155.960 supports value-
48 based decision-making and reducing the burden of preventable disease as broad strategies for
49 addressing rising health care costs. Moreover, this policy recognizes the role of physician
50 leadership and collaboration among physicians, patients, insurers, employers, unions, and
51 government in successful cost-containment and quality-improvement initiatives. The policy

encourages third-party payers to use targeted benefit design, whereby patient cost-sharing is determined based on the clinical value of a health care service or treatment, with consideration given to further tailoring cost-sharing to patient income and other factors known to impact compliance. Policy H-185.939 broadly supports flexibility in the design and implementation of VBID programs and outlines a series of guiding principles including that VBID explicitly consider the clinical benefit of a given service or treatment when determining cost-sharing or other benefit design elements. Consistent with calls to remove legislative and regulatory barriers to innovation in HSA-HDHP plan design, Policy H-165.856 states that the regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. At the same time, Policy H-165.856 states that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options.

AMA ACTIVITY

In addition to the substantial volume of related AMA policy, AMA activities regarding high-value services have included:

- Serving as a liaison to expert organizations including the USPSTF, the ACIP, and Bright Futures.
- At the 2018 Annual Meeting, Policy H-185.960 was modified to specify that the AMA will develop a coding guide regarding colorectal cancer screening services to promote common understanding among health care providers, payers, health care information technology vendors, and patients.
- At the 2018 Annual Meeting, Resolution 226-A-18 regarding routine preventive prostate cancer screening was referred, and the Council on Medical Service is preparing a report for the 2019 Annual Meeting.
- As part of its strategic focus on improving health outcomes, the AMA has partnered with the CDC and DPPs to prevent type 2 diabetes and supports key legislation to prevent type 2 diabetes and improve care for current patients. As a part of these efforts, the AMA has also urged both private and public health care payers to offer DPPs under their health plans to give more people access to these proven programs.⁸⁷
- To address significant barriers to colorectal cancer screening for the Medicare population, AMA advocacy efforts supported requiring Medicare to waive the coinsurance for colorectal screening tests, regardless of whether therapeutic intervention is required during the procedure.
- Various AMA advocacy efforts have supported expansion of the MA VBID Model, including support for flexibility in MA uniformity (which would allow plan sponsors to target enhanced benefit design to certain patients) and support for the Bipartisan Budget Act of 2018 (which incorporates the CHRONIC Care Act of 2017, which includes expansion of the MA VBID Model to all 50 states).
- In July 2018, the AMA sent a letter to Chairman Kevin Brady and Ranking Member Richard Neal of the House of Representatives Committee on Ways and Means supporting H.R. 6301, “to amend the Internal Revenue Code of 1986 to provide high deductible health plans with first dollar coverage flexibility.” H.R. 6301 would expand the access and enhance the utility of HSAs by offering health plans some flexibility in their plan design while still maintaining eligibility for HSA contributions.
- To help AMA members better understand the USPSTF’s methods for making evidence-based recommendations on clinical preventive services and how VBID can be used to expand affordable access to high-value services, the AMA held a continuing medical education session at the 2018 Annual Meeting.

DISCUSSION

Stakeholders throughout the health care community -- providers, payers, community health professionals, and patients -- can benefit from common understanding of which preventive services are covered without patient cost-sharing, and how such services should be coded. Moreover, stakeholders throughout the health care community should contribute to patient education regarding both the health care and economic value of zero-dollar preventive services so that patients can make well-informed decisions about their care. Physicians must be well-aware of recommended services available without cost-sharing so that they can have optimally productive consultations with their patients. The fact that these services are evidence-based and available at no cost to the patient may help physicians communicate the value of these services and help patients understand that cost should not be a barrier to this care. At the same time, proactive conversations between physicians and their patients about how a zero-dollar preventive service can lead to additional items or services that will incur cost-sharing will foster trust and understanding, and avoid unexpected medical bills. Additionally, public health organizations and payers (eg, employers and health plans) should be encouraged to educate the public/their members about recommended preventive services and their availability without cost-sharing. Such educational initiatives will empower patients to have productive conversations with their physicians about whether these services are appropriate for them.

The AMA can play a critical leadership role in building needed common understanding. The AMA, as the authority on CPT, is in a unique position to issue educational materials that can be seen as a source of truth in aligning recommended preventive services with the proper CPT codes for billing. Accordingly, the Councils recommend that the AMA develop coding guidance to help physicians correctly bill, and help payers correctly pay for, recommended preventive services. Additionally, the Councils recommend that the AMA develop physician education tools that help physicians prepare for conversations with their patients about the scope of preventive services provided without cost-sharing. This physician education can be designed to address two needs. First, these educational tools can address underutilization of zero-dollar preventive services by helping physicians communicate the clinical and financial value of these services to their patients. Second, these educational tools can address the patient experience of unexpected medical bills by preparing physicians (and their staff) to have proactive conversations about what is and is not provided within the scope of zero-dollar preventive services.

The USPSTF and the other ACA-designated expert organizations cannot reasonably be expected to develop recommendations on every risk-reducing course of action for every disease. At the same time, it is difficult to rationalize why some individuals at heightened risk for some diseases receive valuable preventive interventions without cost-sharing and others do not. To supplement the work being done by the expert organizations, health plans can choose to incorporate VBID principles to better align patients' clinical and financial incentives, and thereby enhance access to high-value care.

As described above, the AMA has strong policy supporting APMs and VBID. The Councils recommend supporting initiatives that align provider-facing financial incentives created through payment reform, such as APMs, with patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care. Such initiatives may include reducing patient cost-sharing for items and services that are tied to provider quality metrics. Additionally, the Councils recommend reaffirming Policy H-155.960 which supports VBID principles, Policy H-185.939 which supports flexibility in VBID program design, and Policy H-165.856 which supports a regulatory environment that enables private market innovation in product development and purchasing arrangements.

1 It may be challenging to reasonably limit what qualifies as a high-value service designated for
2 reduced cost-sharing. Similarly, the full costs and benefits of VBID plans may only be evident over
3 extended time horizons, so the evidence base will continue to evolve. Accordingly, rather than
4 recommending any single plan design, it is important to support the creation of a legal and
5 regulatory environment that cultivates innovation and freedom to experiment with transformational
6 plan designs. At the same time, innovations in plan design should be consistent with the principles
7 of adequacy of health insurance coverage outlined in Policy H-165.846. Specifically, the AMA
8 should support: removing legal and regulatory barriers to innovative plan designs that seek to
9 encourage high-value care with reduced costs to patients; promoting not only screenings to identify
10 risk, but also high-value care to help patients manage that risk and prevent advanced disease; and
11 allowing HSA-HDHPs to provide pre-deductible coverage for preventive and chronic care
12 management services. In addition, the Councils recommend that as health plans experiment with
13 innovative VBID plans, these plans incorporate the tenets of “clinical nuance” to recognize
14 individual variation and to respect individual needs.

15
16 While continuing to advocate for legal change, there are concrete actions physicians can currently
17 take to apply VBID principles. As plans continue to innovate around VBID, organized medicine
18 and physicians will have a critical role in helping plans understand the highest value care they want
19 to encourage. The exact same service may be highly valuable for some patients, but constitute
20 over-treatment for other patients, and the physician community can lead the way in shaping
21 policies that recognize and embrace this approach to payment reform and benefit design.
22 Continuing with the breast cancer prevention example introduced above, for some women, the
23 USPSTF recommended screening mammography may be all that is needed to effectively manage
24 breast cancer risk. For other women, however, more frequent imaging can be life-saving, high-
25 value care. While these services could be expensive in the short-term, they can prevent more likely
26 cases of deadly (and expensive) disease.

27
28 Accordingly, it will be incumbent upon organized medicine, specifically national medical specialty
29 societies, to collaborate with payers, educating them about the circumstances under which their
30 specialties are providing especially high-value care, care that is most clinically important to
31 incentivize. Physicians can work to identify and highlight the items and services within their areas
32 of specialty that are of highest value, such as those that promote proactive healthy behaviors and/or
33 manage risk or chronic conditions. For example, in looking to evidence-based quality metrics as
34 indicators of high-value care, physicians of all specialties can play a critical role in shaping VBID
35 programs to come. National medical specialty societies should collaborate with payers to shape the
36 designation of “high-value” services and the financial and other incentives that would promote
37 their access and utilization.

38 39 RECOMMENDATIONS

40
41 The Council on Medical Service and the Council on Science and Public Health recommend that the
42 following be adopted and that the remainder of the report be filed:

- 43
44 1. That our American Medical Association (AMA) reaffirm Policy H-155.960, which: supports
45 “value-based decision-making” and reducing the burden of preventable disease as broad
46 strategies for addressing rising health care cost; recognizes the important role of physician
47 leadership, as well as collaboration among physicians, patients, insurers, employers, unions,
48 and government in successful cost-containment and quality-improvement initiatives; and
49 encourages third-party payers to use targeted benefit design, whereby patient cost-sharing
50 requirements are determined based on the clinical value of a health care service or treatment,

- 1 with consideration given to further tailoring cost-sharing requirements to patient income and
2 other factors known to impact compliance. (Reaffirm HOD Policy)
3
- 4 2. That our AMA reaffirm Policy H-185.939, which supports flexibility in the design and
5 implementation of Value-Based Insurance Design (VBID) programs and outlines guiding
6 principles including that VBID explicitly consider the clinical benefit of a given service or
7 treatment when determining cost-sharing or other benefit design elements, and that practicing
8 physicians, including appropriate specialists, must be actively involved in the development of
9 VBID programs. (Reaffirm HOD Policy)
10
- 11 3. That our AMA reaffirm Policy H-165.856, which supports a regulatory environment that
12 enables rather than impedes private market innovation in product development and purchasing
13 arrangements. (Reaffirm HOD Policy)
14
- 15 4. That our AMA support VBID plans designed in accordance with the tenets of “clinical
16 nuance,” recognizing that (1) medical services may differ in the amount of health produced,
17 and (2) the clinical benefit derived from a specific service depends on the person receiving it,
18 as well as when, where, and by whom the service is provided. (New HOD Policy)
19
- 20 5. That our AMA support initiatives that align provider-facing financial incentives created
21 through payment reform and patient-facing financial incentives created through benefit design
22 reform, to ensure that patient, provider, and payer incentives all promote the same quality care.
23 Such initiatives may include reducing patient cost-sharing for the items and services that are
24 tied to provider quality metrics. (New HOD Policy)
25
- 26 6. That our AMA develop coding guidance tools to help providers appropriately bill for zero-
27 dollar preventive interventions and promote common understanding among health care
28 providers, payers, patients, and health care information technology vendors regarding what will
29 be covered at given cost-sharing levels. (Directive to Take Action)
30
- 31 7. That our AMA develop physician educational tools that prepare physicians for conversations
32 with their patients about the scope of preventive services provided without cost-sharing and
33 instances where and when preventive services may result in financial obligations for the
34 patient. (Directive to Take Action)
35
- 36 8. That our AMA continue to support requiring private health plans to provide coverage for
37 evidence-based preventive services without imposing cost-sharing (such as co-payments,
38 deductibles, or coinsurance) on patients. (New HOD Policy)
39
- 40 9. That our AMA continue to support implementing innovative VBID programs in Medicare
41 Advantage plans. (New HOD Policy)
42
- 43 10. That our AMA support legislative and regulatory flexibility to accommodate VBID that
44 (a) preserves health plan coverage without patient cost-sharing for evidence-based preventive
45 services; and (b) allows innovations that expand access to affordable care, including changes
46 needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide
47 pre-deductible coverage for preventive and chronic care management services. (New HOD
48 Policy)

- 1 11. That our AMA encourage national medical specialty societies to identify services that they
- 2 consider to be high-value and collaborate with payers to experiment with benefit plan designs
- 3 that align patient financial incentives with utilization of high-value services. (New HOD
- 4 Policy)

Fiscal Note: \$6,000

REFERENCES

- ¹ Matthew Rae, Gary Claxton, Larry Levitt. Do Health Plan Enrollees have Enough Money to Pay Cost Sharing? The Henry J. Kaiser Family Foundation. November 2017 Issue Brief. Available at: <http://files.kff.org/attachment/Issue-Brief-Do-Health-Plan-Enrollees-have-Enough-Money-to-Pay-Cost-Sharing>. Accessed 4-18-18.
- ² West Health Institute and NORC at the University of Chicago. Americans' Views of Healthcare Costs, Coverage, and Policy. Issue Brief March 2018. Available at: <http://www.westhealth.org/wp-content/uploads/2018/03/WHI-Healthcare-Costs-Coverage-and-Policy-Issue-Brief.pdf>. Accessed 4-19-18.
- ³ American Medical Association interview with A. Mark Fendrick, July 10, 2018.
- ⁴ Ashley Kirzinger, Elise Sugarman, Mollyann Brodie. Kaiser Health Tracking Poll: November 2016. Published: December 1, 2016. Available at: <https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-november-2016/>. Accessed 4-18-18.
- ⁵ McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med*. 2003;348:2635-2645.
- ⁶ Skopec L. and Sommers BD. Seventy-one million additional Americans are receiving preventive services coverage without cost-sharing under the Affordable Care Act. Issue Brief, March 18, Assist. Secr. Plan. Eval., Washington, DC. Available at https://aspe.hhs.gov/system/files/pdf/76626/ib_prevention.pdf. Accessed May 16, 2018.
- ⁷ Ladapo JA and Chokshi DA. Changes in Cardiovascular Care Provision After the Affordable Care Act. *Am J Manag Care*. 2017; 23(11): e366-e373.
- ⁸ Hong YR, Jo A, and Mainous AG. Up-to-Date on Preventive Care Services Under Affordable Care Act: A Trend Analysis From MEPS 2007-2014. *Med Care*. 2017 Aug;55(8):771-780.
- ⁹ Hong YR, Jo A, and Mainous AG. Up-to-Date on Preventive Care Services Under Affordable Care Act: A Trend Analysis From MEPS 2007-2014. *Med Care*. 2017 Aug;55(8):771-780.
- ¹⁰ Hong YR, Jo A, and Mainous AG. Up-to-Date on Preventive Care Services Under Affordable Care Act: A Trend Analysis From MEPS 2007-2014. *Med Care*. 2017 Aug;55(8):771-780.
- ¹¹ Rebecca L. Siegel, et. al. An Assessment of Progress in Cancer Control. *CA CANCER J CLIN*. (First published online July 10, 2018, prior to inclusion in an issue). Available at: <https://onlinelibrary.wiley.com/doi/full/10.3322/caac.21460>. Accessed 7-19-18.
- ¹² Sabik LM, Adunlin G. The ACA and Cancer Screening and Diagnosis. *Cancer journal (Sudbury, Mass)*. 2017;23(3):151-162.
- ¹³ A. Mark Fendrick, et al. Health Savings Account Eligible High Deductible Health Plans: Updating the Definition of Prevention. University of Michigan, Center for Value-Based Insurance Design. May 2014. Available at: <http://vbidcenter.org/wp-content/uploads/2014/08/HDHP-white-paper-final.pdf>. Accessed 4-18-18.
- ¹⁴ A. Mark Fendrick, et al. Health Savings Account Eligible High Deductible Health Plans: Updating the Definition of Prevention. University of Michigan, Center for Value-Based Insurance Design. May 2014. Available at: <http://vbidcenter.org/wp-content/uploads/2014/08/HDHP-white-paper-final.pdf>. Accessed 4-18-18.
- ¹⁵ Rajender Agarwal, Olena Mazurenko, Nir Menachemi. High-Deductible Health Plans Reduce Health Care Cost And Utilization, Including Use Of Needed Preventive Services. *Health Affairs*. October 2017. Available at: <https://doi.org/10.1377/hlthaff.2017.0610>. Accessed 5-4--18.
- ¹⁶ Kaiser Family Foundation, Preventive Services Covered by Private Health Plans under the Affordable Care Act. August 4, 2015. Available at: <https://www.kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/#footnote-160040-19>. Accessed 5-4-18.
- ¹⁷ A. Mark Fendrick, Michael E. Chernew. Precision Benefit Design—Using “Smarter” Deductibles to Better Engage Consumers and Mitigate Cost-Related Nonadherence. *JAMA Intern Med*. 2017;177(3):368-370. doi:10.1001/jamainternmed.2016.8747. March 2017. Available at: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2596004>. Accessed 4-18-18.
- ¹⁸ Sara R. Collins, Munira Z. Gunja, and Michelle M. Doty. How Well Does Insurance Coverage Protect Consumers from Health Care Costs? Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016. *The Commonwealth Fund*. October 18, 2017. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2017/oct/how-well-does-insurance-coverage-protect-consumers-health-care>. Accessed 7-20-18.

- ¹⁹ Rajender Agarwal, Olena Mazurenko, Nir Menachemi. High-Deductible Health Plans Reduce Health Care Cost And Utilization, Including Use Of Needed Preventive Services. *Health Affairs*. October 2017. Available at: <https://doi.org/10.1377/hlthaff.2017.0610>. Accessed 4-18-18.
- ²⁰ A. Mark Fendrick, et al. Incorporating Value-Based Insurance Design to Improve Chronic Disease Management in the Medicare Advantage Program. University of Michigan Center for Value-Based Insurance Design. August 2016. Available at: http://vbidcenter.org/wp-content/uploads/2016/08/MA-White-Paper_final-8-16-16.pdf. Accessed 4-18-18.
- ²¹ A. Mark Fendrick, et al. Incorporating Value-Based Insurance Design to Improve Chronic Disease Management in the Medicare Advantage Program. University of Michigan Center for Value-Based Insurance Design. August 2016. Available at: http://vbidcenter.org/wp-content/uploads/2016/08/MA-White-Paper_final-8-16-16.pdf. Accessed 4-18-18.
- ²² A. Mark Fendrick, et al. Incorporating Value-Based Insurance Design to Improve Chronic Disease Management in the Medicare Advantage Program. University of Michigan Center for Value-Based Insurance Design. August 2016. Available at: http://vbidcenter.org/wp-content/uploads/2016/08/MA-White-Paper_final-8-16-16.pdf. Accessed 4-18-18.
- ²³ A. Mark Fendrick, et al. Incorporating Value-Based Insurance Design to Improve Chronic Disease Management in the Medicare Advantage Program. University of Michigan Center for Value-Based Insurance Design. August 2016. Available at: http://vbidcenter.org/wp-content/uploads/2016/08/MA-White-Paper_final-8-16-16.pdf. Accessed 4-18-18.
- ²⁴ Jason D. Buxbaum, et al. Cost Sharing and Branded Antidepressant Initiation Among Patients Treated With Generics. *The American Journal of Managed Care*. April 2018. Available at: <http://www.ajmc.com/journals/issue/2018/2018-vol24-n4/cost-sharing-and-branded-antidepressant-initiation-among-patients-treated-with-generics>. Accessed 4-25-18.
- ²⁵ Rajender Agarwal, Ashutosh Gupta, and A. Mark Fendrick. Value-Based Insurance Design Improves Medication Adherence Without An Increase In Total Health Care Spending. *Health Affairs*. July 2018. Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1633>. Accessed 7-19-18.
- ²⁶ University of Michigan, Center for Value-Based Insurance Design. V-BID in Action: The Role of Cost-Sharing in Health Disparities. V-BID Center Brief. August 26, 2016. Available at: <http://vbidcenter.org/v-bid-in-action-the-role-of-cost-sharing-in-health-disparities/>. Accessed 4-18-18.
- ²⁷ Rajender Agarwal, Olena Mazurenko, Nir Menachemi. High-Deductible Health Plans Reduce Health Care Cost And Utilization, Including Use Of Needed Preventive Services. *Health Affairs*. October 2017. Available at: <https://doi.org/10.1377/hlthaff.2017.0610>. Accessed 4-18-18.
- ²⁸ Rajender Agarwal, Olena Mazurenko, Nir Menachemi. High-Deductible Health Plans Reduce Health Care Cost And Utilization, Including Use Of Needed Preventive Services. *Health Affairs*. October 2017. Available at: <https://doi.org/10.1377/hlthaff.2017.0610>. Accessed 4-18-18.
- ²⁹ Rajender Agarwal, Olena Mazurenko, Nir Menachemi. High-Deductible Health Plans Reduce Health Care Cost And Utilization, Including Use Of Needed Preventive Services. *Health Affairs*. October 2017. Available at: <https://doi.org/10.1377/hlthaff.2017.0610>. Accessed 4-18-18.
- ³⁰ Rajender Agarwal, Olena Mazurenko, Nir Menachemi. High-Deductible Health Plans Reduce Health Care Cost And Utilization, Including Use Of Needed Preventive Services. *Health Affairs*. October 2017. Available at: <https://doi.org/10.1377/hlthaff.2017.0610>. Accessed 4-18-18.
- ³¹ Rajender Agarwal, Olena Mazurenko, Nir Menachemi. High-Deductible Health Plans Reduce Health Care Cost And Utilization, Including Use Of Needed Preventive Services. *Health Affairs*. October 2017. Available at: <https://doi.org/10.1377/hlthaff.2017.0610>. Accessed 4-18-18.
- ³² Robin A. Cohen, et al. Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–March 2018. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey Early Release Program. Available at: <https://www.cdc.gov/nchs/data/nhis/earlyrelease/Insur201808.pdf>. Accessed 9-7-18.
- ³³ Sara R. Collins, Munira Z. Gunja, and Michelle M. Doty. How Well Does Insurance Coverage Protect Consumers from Health Care Costs? Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016. *The Commonwealth Fund*. October 18, 2017. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2017/oct/how-well-does-insurance-coverage-protect-consumers-health-care>. Accessed 7-20-18.

- ³⁴ Rajender Agarwal, Olena Mazurenko, Nir Menachemi. High-Deductible Health Plans Reduce Health Care Cost And Utilization, Including Use Of Needed Preventive Services. *Health Affairs*. October 2017. Available at: <https://doi.org/10.1377/hlthaff.2017.0610>. Accessed 4-18-18.
- ³⁵ A. Mark Fendrick, Michael E. Chernew. Precision Benefit Design—Using “Smarter” Deductibles to Better Engage Consumers and Mitigate Cost-Related Nonadherence. *JAMA Intern Med*. 2017;177(3):368-370. doi:10.1001/jamainternmed.2016.8747. March 2017. Available at: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2596004>. Accessed 4-18-18.
- ³⁶ A. Mark Fendrick, et al. Health Savings Account Eligible High Deductible Health Plans: Updating the Definition of Prevention. University of Michigan, Center for Value-Based Insurance Design. May 2014. Available at: <http://vbidcenter.org/wp-content/uploads/2014/08/HDHP-white-paper-final.pdf>. Accessed 4-18-18.
- ³⁷ Xinke Zhang, Erin Trish, Neeraj Sood. Financial Burden of Healthcare Utilization in Consumer-Directed Health Plans. *Am J Manag Care*. 2018;24(4):e115-e121. Available at: <http://www.ajmc.com/journals/issue/2018/2018-vol24-n4/financial-burden-of-healthcare-utilization-in-consumer-directed-health-plans>. Accessed 4-18-18.
- ³⁸ Gary Claxton, Larry Levitt, Matthew Rae and Bradley Sawyer. Increases in cost-sharing payments continue to outpace wage growth. *Kaiser Family Foundation*. June 15, 2018. Available at: https://www.healthsystemtracker.org/brief/increases-in-cost-sharing-payments-have-far-outpaced-wage-growth/?_sft_category=spending#item-start. Accessed 7-24-18.
- ³⁹ Gary Claxton, Larry Levitt, Matthew Rae and Bradley Sawyer. Increases in cost-sharing payments continue to outpace wage growth. *Kaiser Family Foundation*. June 15, 2018. Available at: https://www.healthsystemtracker.org/brief/increases-in-cost-sharing-payments-have-far-outpaced-wage-growth/?_sft_category=spending#item-start. Accessed 7-24-18.
- ⁴⁰ Gary Claxton, Larry Levitt, Matthew Rae and Bradley Sawyer. Increases in cost-sharing payments continue to outpace wage growth. *Kaiser Family Foundation*. June 15, 2018. Available at: https://www.healthsystemtracker.org/brief/increases-in-cost-sharing-payments-have-far-outpaced-wage-growth/?_sft_category=spending#item-start. Accessed 7-24-18.
- ⁴¹ Naomi Seiler, Mary-Beth Malcarney, Katie Horton, Scott Dafflitto. Coverage of Clinical Preventive Services Under the Affordable Care Act: From Law to Access. *Public Health Rep*. 2014 Nov-Dec; 129(6): 526–532. doi: 10.1177/003335491412900611. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4187299/>. Accessed 4-18-18.
- ⁴² United States Preventive Services Task Force, Final Recommendation Statement, Colorectal Cancer: Screening. Available at: <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2#consider>. Accessed 4-19-18.
- ⁴³ American Cancer Society, Insurance Coverage for Colorectal Cancer Screening. Available at: <https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/screening-coverage-laws.html>. Accessed 4-19-18.
- ⁴⁴ United States Preventive Services Task Force, Final Recommendation Statement, Breast Cancer: Screening. Available at: <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/breast-cancer-screening1>. Accessed 4-19-18.
- ⁴⁵ United States Preventive Services Task Force, Final Recommendation Statement, Breast Cancer: Screening. Available at: <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/breast-cancer-screening1>. Accessed 7-26-18.
- ⁴⁶ United States Preventive Services Task Force, Final Recommendation Statement, Breast Cancer: Medications for Risk Reduction. Available at: <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/breast-cancer-medications-for-risk-reduction>. Accessed 4-19-18.
- ⁴⁷ United States Preventive Services Task Force, Final Recommendation Statement, Skin Cancer Prevention: Behavioral Counseling. Available at: <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/skin-cancer-counseling2>. Accessed 4-19-18.
- ⁴⁸ United States Preventive Services Task Force, Final Recommendation Statement, Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening. Available at:

<https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/screening-for-abnormal-blood-glucose-and-type-2-diabetes>. Accessed 4-19-18.

⁴⁹ United States Preventive Services Task Force, Final Recommendation Statement, Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening. Available at: <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/screening-for-abnormal-blood-glucose-and-type-2-diabetes>. Accessed 4-26-18.

⁵⁰ The Community Guide, Diabetes Prevention: Interventions Engaging Community Health Workers. Available at: <https://www.thecommunityguide.org/findings/diabetes-prevention-interventions-engaging-community-health-workers>. Accessed 4-26-18.

⁵¹ The Community Guide, Diabetes: Combined Diet and Physical Activity Promotion Programs to Prevent Type 2 Diabetes Among People at Increased Risk. Available at: <https://www.thecommunityguide.org/findings/diabetes-combined-diet-and-physical-activity-promotion-programs-prevent-type-2-diabetes>. Accessed 4-26-18.

⁵² National Diabetes Education Initiative, American Diabetes Association (ADA) 2016 Guidelines, Diabetes Management Guidelines. Available at: <http://www.ndei.org/ADA-diabetes-management-guidelines-microvascular-complications-neuropathy-retinopathy-nephropathy-diabetic-kidney-diseasefoot-care.aspx.html>. Accessed 4-26-18.

⁵³ Julie Appleby. Hospitals Lure Diabetes Patients With Self-Care Courses, But Costs Can Weigh Heavily. *Kaiser Health News*. April 26, 2018. Available at: https://khn.org/news/hospitals-lure-diabetes-patients-with-self-care-courses-but-costs-can-weigh-heavily/?utm_campaign=KHN%3A%20Daily%20Health%20Policy%20Report&utm_source=hs_email&utm_medium=email&utm_content=62403158&_hsenc=p2ANqtz-8BCRQvG2d5hgrysaapdWM1U3yOLbxB2hIGrC57WPZYKja4mXhmSyHtHnLS85bxcSJY0guodqNwEWV NnwXRjzSDVs2iOw&_hsmi=62403158. Accessed 4-26-18.

⁵⁴ A. Mark Fendrick, et al. Incorporating Value-Based Insurance Design to Improve Chronic Disease Management in the Medicare Advantage Program. University of Michigan Center for Value-Based Insurance Design. August 2016. Available at: http://vbidcenter.org/wp-content/uploads/2016/08/MA-White-Paper_final-8-16-16.pdf. Accessed 4-18-18.

⁵⁵ Jason D. Buxbaum, et al. Cost Sharing and Branded Antidepressant Initiation Among Patients Treated With Generics. *The American Journal of Managed Care*. April 2018. Available at: <http://www.ajmc.com/journals/issue/2018/2018-vol24-n4/cost-sharing-and-branded-antidepressant-initiation-among-patients-treated-with-generics>. Accessed 4-25-18.

⁵⁶ Michael E. Chernew, J. Sanford Schwartz, A. Mark Fendrick. Reconciling Prevention And Value In The Health Care System. *Health Affairs Blog*. March 11, 2015. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20150311.045208/full/>. Accessed 4-19-18.

⁵⁷ Michael E. Chernew, J. Sanford Schwartz, A. Mark Fendrick. Reconciling Prevention And Value In The Health Care System. *Health Affairs Blog*. March 11, 2015. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20150311.045208/full/>. Accessed 4-19-18.

⁵⁸ West Health Institute and NORC at the University of Chicago. Americans' Views of Healthcare Costs, Coverage, and Policy. Issue Brief March 2018. Available at: <http://www.westhealth.org/wp-content/uploads/2018/03/WHI-Healthcare-Costs-Coverage-and-Policy-Issue-Brief.pdf>. Accessed 4-19-18.

⁵⁹ A. Mark Fendrick. Alignment of Consumer and Provider Incentives: As Easy as Peanut Butter and Jelly. *The American Journal of Accountable Care*. September 2014. Available at: <https://www.ajmc.com/journals/ajac/2014/2014-1-vol2-n3/alignment-of-consumer-and-provider-incentives-as-easy-as-peanut-butter-and-jelly>. Accessed 7-18-18.

⁶⁰ A. Mark Fendrick. Alignment of Consumer and Provider Incentives: As Easy as Peanut Butter and Jelly. *The American Journal of Accountable Care*. September 2014. Available at: <https://www.ajmc.com/journals/ajac/2014/2014-1-vol2-n3/alignment-of-consumer-and-provider-incentives-as-easy-as-peanut-butter-and-jelly>. Accessed 7-18-18.

⁶¹ Richard A. Hirth, et al. Connecticut's Value-Based Insurance Plan Increased The Use Of Targeted Services And Medication Adherence. *Health Affairs*. April 2016. Available at: <https://doi.org/10.1377/hlthaff.2015.1371>. Accessed 4-19-18.

⁶² American Medical Association, Report of the Council on Medical Service. Value Based Insurance Design. CMS Report 2-A-13. Available at: <https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/a13-cms-report2.pdf>. Accessed 4-26-18.

- ⁶³ Fendrick, AM, Chernew, M, Levi, GW. Value-Based Insurance Design: Embracing Value Over Cost Alone. *The American Journal of Managed Care*. 2009; 15(10):S277-S283. Available at: [http://www.sph.umich.edu/vbidcenter/registry/pdfs/A264_09dec_FendrickS277to283\[1\].pdf](http://www.sph.umich.edu/vbidcenter/registry/pdfs/A264_09dec_FendrickS277to283[1].pdf)
- ⁶⁴ Fendrick, AM, Chernew, M, Levi, GW. Value-Based Insurance Design: Embracing Value Over Cost Alone. *The American Journal of Managed Care*. 2009; 15(10):S277-S283. Available at: [http://www.sph.umich.edu/vbidcenter/registry/pdfs/A264_09dec_FendrickS277to283\[1\].pdf](http://www.sph.umich.edu/vbidcenter/registry/pdfs/A264_09dec_FendrickS277to283[1].pdf)
- ⁶⁵ Center for Value Based Insurance Design University of Michigan. Understanding Clinical Nuance. Available at: <http://vbidcenter.org/initiatives/v-bid-clinical-nuance/>. Accessed 4-19-18.
- ⁶⁶ Jason D. Buxbaum, et al. Cost Sharing and Branded Antidepressant Initiation Among Patients Treated With Generics. *The American Journal of Managed Care*. April 2018. Available at: <http://www.ajmc.com/journals/issue/2018/2018-vol24-n4/cost-sharing-and-branded-antidepressant-initiation-among-patients-treated-with-generics>. Accessed 4-25-18.
- ⁶⁷ Rajender Agarwal, Ashutosh Gupta, and A. Mark Fendrick. Value-Based Insurance Design Improves Medication Adherence Without An Increase In Total Health Care Spending. *Health Affairs*. July 2018. Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1633>. Accessed 7-19-18.
- ⁶⁸ Rajender Agarwal, Ashutosh Gupta, and A. Mark Fendrick. Value-Based Insurance Design Improves Medication Adherence Without An Increase In Total Health Care Spending. *Health Affairs*. July 2018. Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1633>. Accessed 7-19-18.
- ⁶⁹ Mark Fendrick. How Smarter Insurance Design Can Curb Sickness and Cut Costs. M Health Lab. March 16, 2016. Available at: <https://labblog.uofmhealth.org/industry-dx/how-smarter-insurance-design-can-curb-sickness-and-cut-costs>. Accessed 4-19-18.
- ⁷⁰ Center for Value Based Insurance Design University of Michigan. Press Release: Government Funding Bill Expands MA V-BID Model Test to All 50 States. February 8, 2018. Available at: <http://vbidcenter.org/chronic-care-act-funding-bill>. Accessed 2-20-18.
- ⁷¹ Centers for Medicare & Medicaid Services. CMS Finalizes Policy Changes and Updates for Medicare Advantage and the Prescription Drug Benefit Program for Contract Year 2019 (CMS-4182-F). April 2, 2018. Available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-02.html>. Accessed 4-20-18. Also see: Center for Value Based Insurance Design University of Michigan. Value-Based Insurance Design – Why Clinically Nuanced Care Became a Game Changer. Available at: <http://vbidcenter.org/wp-content/uploads/2016/10/V-BID-1-Pager-updated-2-8-18.pdf>. Accessed 4-25-18.
- ⁷² Centers for Medicare & Medicaid Services. CMS Finalizes Policy Changes and Updates for Medicare Advantage and the Prescription Drug Benefit Program for Contract Year 2019 (CMS-4182-F). April 2, 2018. Available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-02.html>. Accessed 4-20-18.
- ⁷³ Center for Value Based Insurance Design University of Michigan. Value-Based Insurance Design – Why Clinically Nuanced Care Became a Game Changer. Available at: <http://vbidcenter.org/wp-content/uploads/2016/10/V-BID-1-Pager-updated-2-8-18.pdf>. Accessed 4-25-18.
- ⁷⁴ Richard A. Hirth, et al. Connecticut’s Value-Based Insurance Plan Increased The Use Of Targeted Services And Medication Adherence. *Health Affairs*. April 2016. Available at: <https://doi.org/10.1377/hlthaff.2015.1371>. Accessed 4-25-18.
- ⁷⁵ Richard A. Hirth, et al. Connecticut’s Value-Based Insurance Plan Increased The Use Of Targeted Services And Medication Adherence. *Health Affairs*. April 2016. Available at: <https://doi.org/10.1377/hlthaff.2015.1371>. Accessed 4-25-18.
- ⁷⁶ Richard A. Hirth, et al. Connecticut’s Value-Based Insurance Plan Increased The Use Of Targeted Services And Medication Adherence. *Health Affairs*. April 2016. Available at: <https://doi.org/10.1377/hlthaff.2015.1371>. Accessed 4-25-18.
- ⁷⁷ Center for Disease Control and Prevention. [The 6/18 Initiative: Accelerating Evidence into Action](https://www.cdc.gov/sixteen/). Available at <https://www.cdc.gov/sixteen/>. Accessed May 16, 2018.
- ⁷⁸ Center for Disease Control and Prevention. [The 6/18 Initiative: Accelerating Evidence into Action](https://www.cdc.gov/sixteen/). Available at <https://www.cdc.gov/sixteen/>. Accessed May 16, 2018.
- ⁷⁹ Center for Value Based Insurance Design University of Michigan. The Next Generation Health Savings Account: The “High-Value Health Plan.” Available at: <http://vbidcenter.org/wp-content/uploads/2016/12/HSA-HDHP-Summary-2-8-18.pdf>. Accessed 4-25-18.

⁸⁰ Center for Value Based Insurance Design University of Michigan. The Next Generation Health Savings Account: The “High-Value Health Plan.” Available at: <http://vbidcenter.org/wp-content/uploads/2016/12/HSA-HDHP-Summary-2-8-18.pdf>. Accessed 4-25-18.

⁸¹ Center for Value Based Insurance Design University of Michigan. HSA-High Deductible Health Plans. Available at: <http://vbidcenter.org/initiatives/hsa-high-deductible-health-plans/>. Accessed 4-25-18.

⁸² Center for Value Based Insurance Design University of Michigan. The Next Generation Health Savings Account: The “High-Value Health Plan.” Available at: <http://vbidcenter.org/wp-content/uploads/2016/12/HSA-HDHP-Summary-2-8-18.pdf>. Accessed 4-25-18.

⁸³ Center for Value Based Insurance Design University of Michigan. Value-Based Insurance Design – Why Clinically Nuanced Care Became a Game Changer. Available at: <http://vbidcenter.org/wp-content/uploads/2016/10/V-BID-1-Pager-updated-2-8-18.pdf>. Accessed 4-25-18.

⁸⁴ Center for Value Based Insurance Design University of Michigan. Value-Based Insurance Design – Why Clinically Nuanced Care Became a Game Changer. Available at: <http://vbidcenter.org/wp-content/uploads/2016/10/V-BID-1-Pager-updated-2-8-18.pdf>. Accessed 4-25-18.

⁸⁵ America's Health Insurance Plans (AHIP). Health Savings Accounts and High Deductible Health Plans Grow as Valuable Financial Planning Tools. April 2018. Available at: https://www.ahip.org/wp-content/uploads/2018/04/HSA_Report_4.12.18.pdf. Accessed 4-18-18.

⁸⁶ Mark Fendrick. How Smarter Insurance Design Can Curb Sickness and Cut Costs. M Health Lab. March 16, 2016. Available at: <https://labblog.uofmhealth.org/industry-dx/how-smarter-insurance-design-can-curb-sickness-and-cut-costs>. Accessed 4-19-18.

⁸⁷ AMA Calls for Health Coverage for Diabetes Prevention Programs. June 14, 2016. Available at <https://www.ama-assn.org/ama-calls-health-coverage-diabetes-prevention-programs>. Accessed May 16, 2018.

APPENDIX

Policies Recommended for Reaffirmation

H-155.960 Strategies to Address Rising Health Care Costs

Our AMA:

- (1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;
- (2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease;
- (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and
- (d) promote “value-based decision-making” at all levels;
- (3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;
- (4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;
- (5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;
- (6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
- (7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
- (8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.
- (9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.

(CMS Rep. 8, A-07 Reaffirmed: CMS Rep. 7, A-08 Reaffirmed in lieu of Res. 828, I-08 Reaffirmation A-09 Reaffirmation I-09 Reaffirmation A-11 Reaffirmation I-11 Appended: Res. 239, A-12 Reaffirmed in lieu of Res. 706, A-12 Reaffirmed: CMS Rep. 1, I-12 Modified: CMS Rep. 2, A-13 Reaffirmed in lieu of Res. 122, A-15 Reaffirmed in lieu of: Res. 121, A-16 Reaffirmed: CMS Rep. 05, I-16 Reaffirmation I-16 Reaffirmed in lieu of: Res. 712, A-17)

H-165.856 Health Insurance Market Regulation

Our AMA supports the following principles for health insurance market regulation:

- (1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan.
 - (2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection.
 - (3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges.
 - (4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium.
 - (5) Insured individuals should be protected by guaranteed renewability.
 - (6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices.
 - (7) Guaranteed issue regulations should be rescinded.
 - (8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.
 - (9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage.
 - (10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.
- (CMS Rep. 7, A-03 Reaffirmed: CMS Rep. 6, A-05 Reaffirmation A-07 Reaffirmed: CMS Rep. 2, I-07 Reaffirmed: BOT Rep. 7, A-09 Appended: Res. 129, A-09 Reaffirmed: CMS Rep. 9, A-11 Reaffirmed in lieu of Res. 811, I-11 Reaffirmed in lieu of Res. 109, A-12 Reaffirmed in lieu of Res. 125, A-12 Reaffirmed: Res. 239, A-12 Reaffirmed: CMS Rep. 9, A-14 Reaffirmation: A-17 Reaffirmed: Res. 518, A-17)

H-185.939 Value-Based Insurance Design

Our AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:

- a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.
- b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.
- c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.
- d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.

- e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.
 - f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices.
 - g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.
 - h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.
 - i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972).
- (CMS Rep. 2, A-13 Reaffirmed in lieu of Res. 122, A-15 Reaffirmed in lieu of: Res. 121, A-16 Reaffirmed: CMS Rep. 05, I-16 Reaffirmation I-16 Reaffirmed: Joint CMS/CSAPH Rep. 01, I-17)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801
(I-18)

Introduced by: Medical Student Section

Subject: Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

Whereas, Under Section 1115 of the Social Security Act, the Secretary of Health and Human Services may approve state waivers for demonstration projects that are experimental in nature;¹ and

Whereas, Section 1115 demonstrations allow states to use federal Medicaid funds for costs that would not otherwise be covered, amounting to approximately one-third (over \$100 billion) of Medicaid spending in 2015;^{1,2} and

Whereas, States have used these waivers to expand coverage, change delivery systems, alter benefits and cost sharing, modify provider payments, and extend coverage in emergency situations;³ and

Whereas, Final evaluations of demonstrations have historically been required by the Centers for Medicare & Medicaid Services (CMS) only after the final expiration of the demonstration, rather than at the end of each three-to five-year demonstration cycle;³ and

Whereas, Demonstrations may be renewed for multiple three-to five-year demonstration cycles, resulting in demonstrations running for decades without proper analyses and data reporting;³ and

Whereas, An interim report submitted by the state of Massachusetts to CMS in 2016 regarding a demonstration initially approved in 1997 lacked data measuring the effectiveness of nearly \$700 million used to create and fund new hospital Medicaid payment delivery systems;³ and

Whereas, Massachusetts currently spends approximately 40% of its state budget on Medicaid services, and CMS has previously encouraged the state to move to more aggressive accountability measures;^{4,5} and

Whereas, Recent interim evaluations of demonstrations in Arkansas and Arizona lacked important information necessary for proper assessment of those demonstrations as well;³ and

¹ Demonstration Projects. *Social Security Administration Compilation of the Social Security Laws*. 2014; https://www.ssa.gov/OP_Home/ssact/title11/1115.htm#ftn27. Accessed March 17, 2018.

² MEDICAID DEMONSTRATIONS: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures. *U.S. Government Accountability Office*. 2018; GAO-18-220.

³ Angelette, Stephen and Evans, Jennifer. 1115 Waivers and the Future of Medicaid. *American Bar Association*. 2015; 11(5). https://www.americanbar.org/publications/aba_health_esource/2014-2015/january/1115.html Accessed March 30, 2018.

⁴ Testimony: Joint Hearing of the House & Senate Committees on Ways & Means and the Joint Committee on Health Care Financing. *The Commonwealth of Massachusetts*. 2017:1.

⁵ Sanchez, Jeffrey. Tackling Medicaid in Massachusetts. *Health Affairs Blog*. 2015; <https://www.healthaffairs.org/doi/10.1377/hblog20150622.048691/full/> Accessed April 4, 2018.

Whereas, In ten states, including Arizona, over 75% of the Federal Medicaid Expenditures go towards Section 1115 demonstrations;³ and

Whereas, The U.S Government Accountability Office (GAO) published a study in January 2018 showing that state-led evaluations of demonstrations had limited usefulness for federal decision-making due to the temporal gaps in comprehensive results, and CMS officials acknowledge this fact;³ and

Whereas, The GAO has made the following recommendations to CMS: (1) establish written procedures for requiring final evaluation reports at the end of each demonstration cycle, (2) issue criteria for when it will allow limited evaluations of demonstrations, and (3) establish a policy for publicly releasing findings from federal evaluations of demonstrations;³ and

Whereas, CMS officials have said that the agency plans to require appropriate evaluation at the end of each demonstration cycle, but still lacks any written procedures for implementing these requirements;³ therefore be it

RESOLVED, That our American Medical Association encourage the Centers for Medicare & Medicaid Services to establish written procedures that require final evaluation reports of Section 1115 Demonstrations at the end of each demonstration cycle, regardless of renewal status.
(New HOD Policy)

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

Date Received: 9/21/18

RELEVANT AMA POLICY:

Medicaid Waivers for Managed Care Demonstration Projects H-290.987

(1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package.

Citation: (BOT Rep. 24, A-95; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04; Modified: CMS Rep. 1, A-14)

Opposition to Medicaid Work Requirements H-290.961

Our AMA opposes work requirements as a criterion for Medicaid eligibility.

Citation: Res. 802, I-17; Reaffirmation: A-18

Medicaid Expansion Options and Alternatives H-290.966

1. Our AMA encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap.
2. Our AMA encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low income adult populations.
3. Our AMA encourages the Centers for Medicare & Medicaid Services to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults.
4. Our AMA advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid web site.

Citation: CMS Rep. 5, I-14; Reaffirmed: CMS Rep. 02, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802
(I-18)

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

Subject: Due Diligence for Physicians and Practices Joining an ACO
with Risk Based Models (Up Side and Down Side Risk)

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

Whereas, Recent presentations by CMS Secretary Verma have stressed moving Medicare Shared Savings ACO's to reduce the number of upside only Medicare Shared Savings ACO's (MSSP ACO's) by moving them to a two-track model and reducing the length of time that existing MSSP ACO's can remain in the program to two years and lowering their share of savings to 25%. Telemedicine initiatives were offered as a way to offset the risks. The rationale is that new risk based ACO's will be able to move to Value Based Care as outlined in MACRA. The risk based ACO's will have to remain in the program for 5 years starting in 2020; and

Whereas, Given that 15 of the 18 Next Gen (risk based ACO's) have prior MSSP experience and are huge organizations with prior experience with integration and cost reductions, the fact that they only saved 1.7% is alarming. Eliminating the MSSP prevents new organizations from acquiring the experience in a lower risk environment. (Infrastructure costs, etc. for an ACO). It reinforces the fact that smaller organizations and private practitioners will have no access to APM's and the bonuses related to Value Based Care; and

Whereas, Recent results from CMS MSSP ACO's viewed on the whole do not show consistent "significant savings" for many organizations, and many others show no savings. Thus, making the losses associated with the move to involve "downside risk" even more likely and the pathway more treacherous. (CMS Report 2017).³ This will limit the number of risk-based organizations to only very large previously integrated and well capitalized healthcare systems; and

Whereas, Recent publications (NEJM 9/5/18), four which have done subgroup analyses of the results, have shown a differential in savings when MSSP ACO's owned by physicians are reviewed versus hospital integrated systems. The physician owned systems have substantially greater savings; and

Whereas, Risk based ACO's require prior ACO experience, organizational infrastructure, linked health information technology (HIT), and business resources. Large amounts of capital are necessary to form and run a given system. The necessary funds are only available to large well capitalized health care systems. These requirements create a vulnerability which will lead to further consolidation of medical practices given the need for capital needed to allow them to participate in Advance Payment Models (APM's). Thus, it will also expose integrated healthcare systems to takeovers by financial firms or other larger systems; and

Whereas, consolidation of physicians' practices has not led to greater savings. Further consolidation forced by eliminating the MSSP ACO program may cause some systems to drop out of the MSSP program. This will likely further raise costs while making it impossible for smaller groups of physicians and rural physicians to participate in ACO's. The opportunity to participate in value-based care (APM's) to receive bonuses in MACRA will not be accessible. Elimination and/or modification of MIPS makes the opportunity for bonuses based on superior physician performance impossible; therefore be it

RESOLVED, That our American Medical Association advocate for the continuation of up side only risk Medicare Shared Savings ACO (MSSP ACO) program as an option from the Centers for Medicare and Medicaid Services, particularly for physician owned groups (New HOD Policy); and be it further

RESOLVED, That our AMA develop educational resources and business analytics to help physicians complete due diligence in evaluating the performance of hospital integrated systems before considering consolidation. Specific attention should be given to the evaluation of transparency on past savings results, system finances, quality metrics, physician workforce stability and physician job satisfaction, and the cost of clinical documentation software (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate the characteristics of successful physician owned MSSP ACOs and participation in alternative payment models (APMs) to create a framework of the resources and organizational tools needed to allow smaller practices to form virtual ACOs that would facilitate participation in MSSP ACOs and APMs. (Directive to Take Action)

Fiscal Note: Estimated cost of \$30,000 to implement resolution.

Received: 09/25/18

References

1. Announcing the Next Gen ACO Results
2. AMA Accountable Care Principles 2017
3. Was the Medicare Accountable Care Savings Program Successful in 2017
4. Medicare Spending over 3 year of the shared savings program McWilliam, J M, et. al., N Engl J Med. 2018 Sept. 5
5. Ready or not for Quality Based Re-imbursement
6. Use of EHR's does not reduce Administrative Costs
7. Hospital Consolidation linked to higher healthcare costs
8. MACRA
9. How the Next Gen ACO's compared on savings in 2016
10. The Impact of Hospital Consolidation on Medical Costs
11. The Hidden Cost of Provider Consolidation
12. Next Gen Model Saves 62 Million
13. Scholarly Articles on Consolidation of Medical Practices

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 803
(I-18)

Introduced by: Resident and Fellow Section

Subject: Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of “Dense Breasts” on Mammogram

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

1 Whereas, “Dense breast” tissue makes it harder to identify cancer on a mammogram, especially
2 if there are no calcifications present within the cancerⁱ; and
3

4 Whereas, Patients with “dense breast” tissue are also associated with an increased risk of
5 breast cancer (i.e., the risk is estimated to be four times greater for women with extremely
6 dense breasts versus women with fatty breasts)ⁱ; and
7

8 Whereas, A “negative” screening mammography result does not reliably rule out cancer in
9 women with dense breastsⁱ; and
10

11 Whereas, These women with “dense breast” tissue often have higher stage cancers upon
12 detection due to the fact that they are not discovered until they are larger and symptomaticⁱ; and
13

14 Whereas, Ultrasound and MRI have been shown to reduce interval cancers in women with
15 “dense breasts”ⁱ; and
16

17 Whereas, Approximately 30 states have adopted laws requiring notification to patients with
18 “dense breasts”ⁱⁱ; and
19

20 Whereas, The decision to pursue additional screening should be a result of the conversation
21 between individual patients and their physician-led health care teamⁱ; and
22

23 Whereas, Insurance companies are not required to pay for additional screeningⁱⁱⁱ; therefore be it
24

25 RESOLVED, That our American Medical Association support insurance coverage for
26 supplemental screening recommended for patients with “dense breast” tissue following a
27 conversation between the patient and their physician (New HOD Policy); and be it further
28

29 RESOLVED, That our AMA advocate for insurance coverage for and adequate access to
30 supplemental screening recommended for patients with “dense breast” tissue following a
31 conversation between the patient and their physician. (New HOD Policy)

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

Received: 09/27/18

RELEVANT AMA POLICY

Screening Mammography H-525.993

Our AMA:

- a. recognizes the mortality reduction benefit of screening mammography and supports its use as a tool to detect breast cancer.
- b. recognizes that as with all medical screening procedures there are small, but not inconsequential associated risks including false positive and false negative results and overdiagnosis.
- c. favors participation in and support of the efforts of professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography in reducing breast cancer mortality, as well as its limitations.
- d. advocates remaining alert to new epidemiological findings regarding screening mammography and encourages the periodic reconsideration of these recommendations as more epidemiological data become available.
- e. believes that beginning at the age of 40 years, all women should be eligible for screening mammography.
- f. encourages physicians to regularly discuss with their individual patients the benefits and risks of screening mammography, and whether screening is appropriate for each clinical situation given that the balance of benefits and risks will be viewed differently by each patient.
- g. encourages physicians to inquire about and update each patient's family history to detect red flags for hereditary cancer and to consider other risk factors for breast cancer, so that recommendations for screening will be appropriate.
- h. supports insurance coverage for screening mammography.
- i. supports seeking common recommendations with other organizations, informed and respectful dialogue as guideline-making groups address the similarities and differences among their respective recommendations, and adherence to standards that ensure guidelines are unbiased, valid and trustworthy.
- j. reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians.

Citation: (CSA Rep. F, A-88; Reaffirmed: Res. 506, A-94; Amended: CSA Rep. 16, A-99; Appended: Res. 120, A-02; Modified: CSAPH Rep. 6, A-12)

ⁱ Berg WA. Supplemental Breast Cancer Screening in Women with Dense Breasts Should be Offered with Simultaneous Collection of Outcomes Data. *Annals of internal medicine*. 2016;164(4):299-300. doi:10.7326/M15- 2977.

ⁱⁱ Breast Density Notification Laws by State — Interactive Map. Available at <http://www.diagnosticsimaging.com/breast-imaging/breast-density-notification-laws-state--interactive-map>.

ⁱⁱⁱ Dense Breast Info. Available at <http://densebreast-info.org/legislation.aspx>.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 804
(I-18)

Introduced by: Alaska

Subject: Arbitrary Documentation Requirements for Outpatient Services

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

Whereas, Onerous administrative requirements can reduce practice efficiency and contribute to physician burnout, without improving patient care; and

Whereas, Fee for service payers including Medicare and Medicaid have historically advised that clinical documentation for outpatient services should be completed in a “timely manner” (or within some other non-specific timeframe); and

Whereas, A new Alaska Medicaid regulation arbitrarily imposes a “72 hour” rule, prohibiting payment for any outpatient claim unless documentation for the provided service had been substantively completed within three days of the visit (including weekends/holidays); and

Whereas, Neither government nor private health insurers should unilaterally impose burdensome documentation requirements without at least some evidence that the new rules will improve patient outcomes; and

Whereas, Alaska’s new regulation also includes a provision that the three day requirement shall be waived if a provider’s professional body has adopted policy specifying that a longer time period for documentation is appropriate; therefore be it

RESOLVED, That our American Medical Association agree that documentation for outpatient physician services should be completed in a timely manner (New HOD Policy); and be it further

RESOLVED, That for circumstances in which more specific definitions of timeliness are required, AMA policy is that documentation for outpatient services should be completed, when possible, within 14 days of a provided service (New HOD Policy); and be it further

RESOLVED, That our AMA work with government health plans and private insurers to help them better understand the unintended consequences of imposing documentation rules with unrealistically short timeframes, and that our AMA oppose the use of such rules or regulations in determining whether submitted claims are valid and payable. (Directive to Take Action)

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

Received: 09/28/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805
(I-18)

Introduced by: Florida

Subject: Prompt Pay

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

Whereas, Current AMA policy declares that it is a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days (H-190.959); and

Whereas, The AMA is still working to ensure that the 14-day prompt payment objective is achieved; and

Whereas, Advances in automation and technology enable insurance companies and managed care plans to pay clean claims on the day received; therefore be it

RESOLVED, That American Medical Association policy H-190.959 be amended by addition and deletion to read as follows:

Physician Reimbursement by Health Insurance and Managed Care Companies

1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within ~~fourteen~~ three days.

2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within ~~five~~ one business days to allow prompt resubmission of a clean claim.

3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment. (Modify Current HOD Policy)

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

Received: 09/27/18

RELEVANT AMA POLICY

Physician Reimbursement by Health Insurance and Managed Care Companies H-190.959

1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days.
2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim.
3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment.

Citation: (Sub. Res. 713, A-02; Modified: Res. 714, A-03; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: Res 132, A-14; Reaffirmed: Sub. Res. 715, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 806
(I-18)

Introduced by: AMDA – The Society for Post-Acute and Long-Term Care Medicine

Subject: Telemedicine Models and Access to Care in Post-Acute and Long-Term Care

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

1 Whereas, The Centers for Medicare and Medicaid Services (CMS) authorized virtual clinical
2 visits and payments for such services under the new Physician Fee Schedule (PFS) and Quality
3 Payment Program (QPP) announced in July 2018; and
4

5 Whereas, CMS and numerous participating skilled nursing facilities (SNFs) have generated
6 savings and created efficiencies and better outcomes, including a reduction in avoidable
7 rehospitalizations in post-acute care of Medicare recipients by way of Medicare innovation
8 programs (CMMI), including use of telemedicine and increased availability of medical
9 practitioners onsite; and
10

11 Whereas, CMS has restricted the number of telemedicine encounters allowed per Medicare
12 beneficiary to one per month, instead of frequency based on medical necessity, even as there is
13 demonstrable benefit of such visits for patients who are frail, elderly and have multiple chronic
14 and complex medical care needs along with a lack of ready and timely access to clinical
15 practitioners; therefore be it
16

17 RESOLVED, That our American Medical Association advocate for removal of arbitrary limits on
18 telemedicine visits by medical practitioners in nursing facilities and instead base them purely on
19 medical necessity, and collaborate with AMDA – The Society for Post-Acute and Long-Term
20 Care Medicine to effect a change in Medicare's policy regarding this matter under the provisions
21 of Physician Fee Schedule (PFS) and Quality Payment Program (QPP) (New HOD Policy); and
22 be it further
23

24 RESOLVED, That our AMA work with AMDA-The Society for Post-Acute and Long-Term Care
25 Medicine and other stakeholders to influence Congress to broaden the scope of telemedicine
26 care models in post-acute and long-term care and authorize payment mechanisms for models
27 that are evidence based, relevant to post-acute and long-term care and continue to engage
28 primary care physicians and practitioners in the care of their patients. (Directive to Take Action)

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

Received: 10/03/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807
(I-18)

Introduced by: American College of Emergency Physicians

Subject: Emergency Department Copayments for Medicaid Beneficiaries

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

Whereas, Copayments (copays) for emergency department services have been shown to create a significant barrier to necessary emergency care for Medicaid enrollees¹; and

Whereas, Many Medicaid programs utilize the current federally allowed copay up to eight dollars for emergency department services determined to be non-emergent²; and

Whereas, For the purposes of determining non-emergency, and therefore imposition of copays for Medicaid enrollees, many states use the Emergency Severity Index (ESI) triage levels or final diagnoses rather than the Prudent Layperson Standard³ as directed in the CMS guidance for implementation of such copays⁴; and

Whereas, Our AMA Policy H-130.970 opposes implementation of policies that violate the Prudent Layperson Standard of determining when to seek emergency care⁵; and

Whereas, States are using Section 1115 Medicaid waiver demonstrations to implement emergency department copays of increasing amounts and to apply such emergency department copays even for emergent services; and

Whereas, Medicaid programs that have copays for non-emergent use of the emergency department do not decrease such non-emergent use⁶ and do not decrease overall Medicaid costs⁷; and

Whereas, The calculated effect of Indiana's increased Medicaid emergency department copay (\$25), allowed by a 2015 CMS Medicaid waiver demonstration, used a retrospective definition of "emergency," disregarding the federal Prudent Layperson Standard; and

Whereas, Copays requested at the time of registration in the emergency department could intimidate patients from receiving a mandated medical screening exam, thus placing the hospital at risk for an EMTALA violation⁸; therefore be it

RESOLVED, That our American Medical Association oppose imposition of copays for Medicaid beneficiaries seeking care in the emergency department. (New HOD Policy)

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

Received: 10/10/18

RELEVANT AMA POLICY

Access to Emergency Services H-130.970

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:

(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

(C) All health plans should be prohibited from requiring prior authorization for emergency services.

(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.

(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third party payer whether it is retrospectively determined that an emergency existed or not.

(G) States should be encouraged to enact legislation holding health plans and third party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.

(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.

(I) In instances in which no private or public third party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the prudent layperson standard of determining when to seek emergency care.

Citation: CMS Rep. A, A-89; Modified by CMS Rep. 6, I-95; Reaffirmation A-97; Reaffirmed by Sub. Res. 707, A-98; Reaffirmed: Res. 705, A-99; Reaffirmed: CMS Rep. 3, I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 706, I-00; Amended: Res. 229, A-01; Reaffirmation and Reaffirmed: Res. 708, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 07, A-16; Appended: Res. 128, A-17; Reaffirmation: A-18

References:

¹ Artiga S, Ubrri P, Zur J. The effects of premiums and cost sharing on low-income populations: updated review of research findings. Kaiser Family Foundation. June 1, 2017. <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>

² Medicaid: Cost Sharing Out of Pocket Costs. <https://www.medicaid.gov/medicaid/cost-sharing/out-of-pocket-costs/index>

³ Prudent Layperson Standard - 42 U.S.C. 1395w-22(d)(3)(B) & 1396u-2(b)(2)(C)

⁴ Medicaid Cost-sharing. <https://www.medicaid.gov/medicaid/cost-sharing/index.html> based on 42 CFR 447.5

⁵ Access to Emergency Services (H-130.970). Reaffirmed A-18. <https://policysearch.ama-assn.org/policyfinder/detail/130.970?uri=%2FAMADoc%2FHOD.xml-0-270.xml>

⁶ Mortensen, K. Copayments did not reduce Medicaid enrollees' nonemergency use of emergency departments. *Health Affairs*. 2010; 29(9), abstract <http://content.healthaffairs.org/content/29/9/1643.abstract>

⁷ MACPAC. July 2014. Revisiting Emergency Department Use in Medicaid. https://www.macpac.gov/wp-content/uploads/2015/01/MACFacts-EDUse_2014-07.pdf

⁸ Emergency Medical Treatment and Labor Act - 42 United States Code (U.S.C.) 1395dd

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808
(I-18)

Introduced by: Tennessee

Subject: The Improper Use of Beers or Similar Criteria and Third-Party Payer
Compliance Activities (H-185.940)

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

1 Whereas, The delegation of Tennessee has reviewed Policy H-185.940, adopted A-12, "Beers
2 or Similar Criteria And Third-Party Payer Compliance Activities"; and

3
4 Whereas, There is evidence of fiscal harm to physicians and damage to their professional
5 reputations by the improper application of Beers Criteria within compliance activity; and

6
7 Whereas, A health insurance company doing business in Tennessee has expanded this
8 practice regionally to other states; therefore be it

9
10 RESOLVED, That our American Medical Association identify and establish a workgroup with
11 insurers that are inappropriately applying Beers or similar criteria to quality rating programs and
12 work with the insurers to resolve internal policies that financially penalize physicians (Directive
13 to Take Action); and be it further

14
15 RESOLVED, That our AMA study and report back to the House of Delegates the 2019 Interim
16 Meeting, the potential inappropriate use of Beers Criteria by insurance companies looking at
17 which companies are involved and the effect of the use of these criteria on physicians' practices
18 (Directive to Take Action); and be it further

19
20 RESOLVED, That our AMA provide a mechanism for members to report possible abuses of
21 Beers Criteria by insurance companies. (Directive to Take Action)

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

Received: 10/10/18

RELEVANT AMA POLICY

Beers or Similar Criteria and Third Party Payer Compliances Activities H-185.940

Our AMA adopts policy: (1) discouraging health insurers, benefit managers, and other payers from using the Beers Criteria and other similar lists to definitively determine coverage and/or reimbursement, and inform health insurers and other payers of this policy; and (2) clarifying that while it is appropriate for the Beers Criteria to be incorporated in quality measures, such measures should not be applied in a punitive or onerous manner to physicians and must recognize the multitude of circumstances where deviation from the quality measure may be appropriate, and inform health insurers and other payers of this policy.

Citation: (BOT Rep. 14, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 809
(I-18)

Introduced by: American Society of Clinical Oncology

Subject: Medicaid Clinical Trials Coverage

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

Whereas, Clinical trials are often a patient's best clinical option for combating disease progression; and

Whereas, Guaranteed access to clinical trials is an important part of high-quality care that should be available to all patients with life-threatening conditions regardless of financial circumstances; and

Whereas, Sixty percent of the U.S. population resides at or below 400 percent of the federal poverty level (FPL); therefore, a significant proportion of patients with cancer may be vulnerable to financial toxicity related to the cost of their care;¹ and

Whereas, Nearly 73.4 million people were enrolled in Medicaid and CHIP as of June 2018²; and

Whereas, Costs related to clinical trial participation include those of new drugs or interventions as well those related to routine clinical care; and

Whereas, Routine costs include the non-experimental costs of treating a patient who is participating in a clinical trial, such as physician visits and laboratory studies; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) issued a Medicare National Coverage Determination (NCD) for the Routine Costs in Clinical Trials effective July 9, 2007³ which provided for coverage of these routine costs; and

Whereas, The Patient Protection and Affordable Care Act (ACA) prohibits private health plans or insurers from limiting or denying coverage of routine costs to patients who participate in clinical trials⁴; and

Whereas, Medicaid statutes do not require state Medicaid programs to provide coverage for the routine costs of clinical trials; and

¹ The Kaiser Family Foundation. *Distribution of the Total Population by Federal Poverty Level (above and below 400% FPL)*. 2016. <http://www.kff.org/other/state-indicator/population-up-to-400-fpl/> (Accessed September 17, 2018).

² Centers for Medicare & Medicaid Services. *June 2018 Medicaid & CHIP Enrollment Data Highlights*. 2018. <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html> (Accessed September 18, 2018).

³ Centers for Medicare & Medicaid Services. *National Coverage Determination (NCD) for Routine Costs in Clinical Trials* (310.1). July 9, 2007. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R74NCD.pdf> (Accessed September 20, 2018).

⁴ The Patient Protection and Affordable Care Act, 42 U.S.C.A. § 300gg-8. *Coverage for individuals participating in approved clinical trials*. 2010. <https://medicine.yale.edu/ycci/comply/insurance/ACA%20Statute%2042%20USCA%20300gg-8%20175006%20174718%2010115%20v1.pdf> (Accessed September 20, 2018).

1 Whereas, State Medicaid programs which do cover the routine costs of patients on clinical trials
2 have policies that vary significantly by state⁵; and
3

4 Whereas, Minorities are not well represented in clinical trials, and Medicaid serves a large
5 portion of under-represented minorities; and
6

7 Whereas, Reducing participant burdens in clinical trials is advantageous to recruiting minority
8 populations⁶, which helps to address unacceptable health disparities in cancer; and
9

10 Whereas, Several studies demonstrate that providing coverage for the routine costs of clinical
11 trials have a minimal effect on overall care costs⁷; therefore be it
12

13 RESOLVED, That our American Medical Association actively lobby for and support federal
14 legislation that guarantees coverage of routine patient care costs for Medicaid enrollees who
15 participate in clinical trials. (Directive to Take Action)

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

Received: 10/11/18

RELEVANT AMA POLICY

Increasing Minority Participation in Clinical Research H-460.911

1. Our AMA advocates that:

- a. The Food and Drug Administration (FDA) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
- b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and
- c. Resources be provided to community level agencies that work with those minorities who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities in clinical trials:

- a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs;
- b. Increased outreach to female physicians to encourage recruitment of female patients in clinical trials;
- c. Continued minority physician education on clinical trials, subject recruitment, subject safety, and possible expense reimbursements;
- d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and

⁵ American Society of Clinical Oncology. *Insurance Coverage of Clinical Trials*. 2018. <https://www.asco.org/research-progress/clinical-trials/insurance-coverage-clinical-trials#ACA> (Accessed September 20, 2018).

⁶ Paskett E, Reeves K, McLaughlin J, Katz M, Scheck McAlearney A, Ruffin M, Hughes Halbert C, Merete C, Davis F, Gehlert S. *Recruitment of Minority and Underserved Populations in the United States: The Centers for Population Health and Health Disparities Experience*. *Contemporary Clinical Trials*. 2008 Nov; 29(6):847-861. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2642621/> (Accessed September 19, 2018).

⁷ Polite BN, Griggs JJ, Moy B, Lathan Christopher, duPont NC, Villani G, Wong S, Halpern MT. *American Society of Clinical Oncology Policy Statement on Medicaid Reform*. *Journal of Clinical Oncology*. 2014 Dec; 32(36): 4162-416. <http://jco.ascopubs.org/content/early/2014/11/12/JCO.2014.56.3452.full.pdf+html> (Accessed September 19, 2018).

e. Fiscal support for minority recruitment efforts and increasing trial accessibility through transportation, child care, reimbursements, and location.

3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.

Citation: BOT Rep. 4, A-08; Reaffirmed: CSAPH Rep. 01, A-18

7.1.1 Physician Involvement in Research

Biomedical and health research is intended to contribute to the advancement of knowledge and the welfare of society and future patients, rather than to the specific benefit of the individuals who participate as research subjects.

However, research involving human participants should be conducted in a manner that minimizes risks and avoids unnecessary suffering. Because research depends on the willingness of participants to accept risk, they must be able to make informed decisions about whether to participate or continue in a given protocol.

Physician researchers share their responsibility for the ethical conduct of research with the institution that carries out research. Institutions have an obligation to oversee the design, conduct, and dissemination of research to ensure that scientific, ethical, and legal standards are upheld. Institutional review boards (IRBs) as well as individual investigators should ensure that each participant has been appropriately informed and has given voluntary consent.

Physicians who are involved in any role in research with human participants have an ethical obligation to ensure that participants interests are protected and to safeguard participants welfare, safety, and comfort.

To fulfill these obligations, individually, physicians who are involved in research should:

- (a) Participate only in those studies for which they have relevant expertise.
- (b) Ensure that voluntary consent has been obtained from each participant or from the participants legally authorized representative if the participant lacks the capacity to consent, in keeping with ethics guidance. This requires that:
 - (i) prospective participants receive the information they need to make well-considered decisions, including informing them about the nature of the research and potential harms involved;
 - (ii) physicians make all reasonable efforts to ensure that participants understand the research is not intended to benefit them individually;
 - (iii) physicians also make clear that the individual may refuse to participate or may withdraw from the protocol at any time.
- (c) Assure themselves that the research protocol is scientifically sound and meets ethical guidelines for research with human participants. Informed consent can never be invoked to justify an unethical study design.
- (d) Demonstrate the same care and concern for the well-being of research participants that they would for patients to whom they provide clinical care in a therapeutic relationship. Physician researchers should advocate for access to experimental interventions that have proven effectiveness for patients.
- (e) Be mindful of conflicts of interest and assure themselves that appropriate safeguards are in place to protect the integrity of the research and the welfare of human participants.
- (f) Adhere to rigorous scientific and ethical standards in conducting, supervising, and disseminating results of the research.

[AMA Principles of Medical Ethics: I,II,III,V](#)

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 810
(I-18)

Introduced by: American Society of Clinical Oncology

Subject: Medicare Advantage Step Therapy

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

Whereas, The Centers for Medicare & Medicaid Services (CMS) announced that Medicare Advantage (MA) plans will have the choice of implementing step therapy to manage Part B drugs beginning January 1, 2019; and

Whereas, This proposal is part of the agency's ongoing activities to deliver on the Trump Administration's American Patients First Blueprint and overall drug pricing initiative; and

Whereas, Step therapy delays patient access to proper treatments by requiring patients to try and fail on lower cost medications before they can access the appropriate medication prescribed by their physician; and

Whereas, In life-threatening illness, including many cancers, step therapy could require use of drug not recommended by the patient's physician, and that failure to optimize treatment at the outset could harm the patient's chances for successful treatment; and

Whereas, Due to the individualized nature of modern cancer treatment and lack of interchangeable clinical options, step therapy policies are inappropriate for use in oncology treatment; and

Whereas, Our AMA's Prior Authorization and Utilization Management Reform Principles emphasize the importance of clinical validity, continuity of care, transparency and fairness, timely access and administrative efficiency, and alternatives and exemptions in order to ensure patient access to appropriate care while reducing the administrative burden associated with policy compliance;¹ and

Whereas, Step therapy is not an effective utilization management policy and hinders access to high-quality, high-value care; therefore be it

RESOLVED, That our American Medical Association continue strong advocacy for the rejection of step therapy in Medicare Advantage plans and impede the implementation of the practice before it takes effect on January 1, 2019. (Directive to Take Action)

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

Received: 10/11/18

¹ American Medical Association. *Prior Authorization and Utilization Management Reform Principles*. January 25, 2017. <https://www.ama-assn.org/ama-news/21-principles-reform-prior-authorization-requirements> (Accessed September 20, 2018).

RELEVANT AMA POLICY

Prescription Drug Plans and Patient Access D-330.910

Our AMA will explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the Centers for Medicare and Medicaid Services and other appropriate organizations to resolve them.

Citation: (Res. 135, A-14)

Prior Authorization and Utilization Management Reform H-320.939

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.

2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.

Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18

Medicare Pharmaceutical Benefit H-330.899

Our AMA utilizes the following principles in evaluating legislative proposals for the addition of a Medicare pharmaceutical benefit:

- (1) Any pharmaceutical benefit should be fully funded by additional budgetary allocations, separate from existing budget provisions. The benefit should provide for adequate accounting so that drug program expenditures can be tracked separately from all other expenditures.
- (2) The pharmaceutical benefit should be targeted to reduce hardship for those with low-incomes and those with catastrophic costs.
- (3) Any legislation should provide a pharmaceutical benefit that is equal across geographic regions.
- (4) A pharmaceutical benefit should be designed in a way that allows for benefits options under both the traditional Medicare fee-for-service program and any version of the Medicare program that relies on the private marketplace. Different levels of drug benefits for different products would be permissible.
- (5) A pharmaceutical benefit should include a tiered deductible and co-payment structure that encourages economically responsible behavior.
- (6) Any pharmaceutical benefit should be designed to prevent adverse selection.
- (7) Any pharmaceutical benefit should be designed in a manner that prevents interference with clinical decision-making and physician prescribing decisions.
- (8) Any pharmaceutical benefit should be designed in a manner that minimizes the administrative burden placed on physicians.
- (9) Any pharmaceutical benefit should be designed in a manner that ensures beneficiary access to local pharmacies, and not be limited to mail order pharmacies.
- (10) In the implementation of any Medicare drug benefit, employers are highly encouraged to preserve existing coverage, and for Medicare beneficiaries with existing drug coverage, any Medicare benefit should be supplemental to and coordinated with that existing coverage.

Citation: BOT Rep. 27, A-00; Reaffirmed: Res. 103, A-01; Modified: CMS Rep. 11, A-02; Modified: CMS Rep. 9, A-03; Appended: Res. 723, I-03; Reaffirmation I-04; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16

Emerging Trends in Utilization Management H-320.958

The AMA will: (1) maintain a leadership role in coordinating private sector efforts to develop and refine utilization management and quality assessment programs; (2) **establish an active role in the development of any national utilization management and quality assessment programs that are proposed in the ongoing health system reform debate; and (3) advocate strongly for utilization management and quality assessment programs that are non-intrusive, have reduced administrative burdens, and allow for adequate input by the medical profession.**

Citation: CMS Rep. 9, I-93; Reaffirmed and Modified: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmation: A-17; Reaffirmation: I-17

Eliminate Fail First Policy in Addiction Treatment H-320.941

Our AMA will advocate for the elimination of the "fail first" policy implemented at times by some insurance companies and managed care organizations for addiction treatment.

Citation: Res. 802, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 811
(I-18)

Introduced by: American Society for Reproductive Medicine

Subject: Infertility Benefits for Active-Duty Military Personnel

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

Whereas, According to Pentagon figures, over 200,000 women are in the active-duty US military, including 74,000 in the Army, 53,000 in the Navy, 62,000 in the Air Force, and 14,000 in the Marine Corps in 2011;¹ and

Whereas, According to the 2012 Committee Opinion on “Health care for women in the military and women Veterans” from the American College of Obstetricians and Gynecologists (ACOG), “military service is associated with unique risks to women’s reproductive health Obstetrician-gynecologists should be aware of high prevalence problems (e.g., posttraumatic stress disorder, intimate partner violence, and military sexual trauma) that can threaten the health and well-being of these women;”³ and

Whereas, Both men and women in our US military can suffer from infertility, sometimes directly as a result of blast traumas and spinal cord injuries;⁴ and

Whereas, The US Department of Defense currently covers the cost of in vitro fertilization (IVF) and infertility services for certain injured active duty personnel;⁵ and

Whereas, Under current Tricare policy, active-duty military personnel and their dependents have some limited coverage for infertility care and oocyte cryopreservation services (with use by only 7181 over 5 years⁶) at seven specific military treatment facilities: Walter Reed National Military Medical Center in Bethesda MD; Womack Army Medical Center at Fort Bragg in Fayetteville NC; San Antonio Military Medical Center in San Antonio TX; San Diego Naval Medical Center in San Diego CA; Tripler Army Medical Center in Honolulu HI; Wright-Patterson Air Force Base Medical Center in Dayton OH; and Madigan Army Medical Center in Seattle-Tacoma WA); and

Whereas, This critical medical service is not fully available to active duty members of the military and those working with the DOD; and

Whereas, In 2016, our AMA passed policy H-510.984 “infertility Benefits for Veterans” ⁶ which states in part that:

3) “Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits through TRICARE and the VA at pre-deployment and during the medical discharge process.

4) Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.”; and

1 Whereas, Unfortunately, many active-duty military personnel are not aware of their infertility
2 benefits under current Tricare policy; therefore be it
3

4 RESOLVED, That our American Medical Association work with the Department of Defense, the
5 American Society for Reproductive Medicine and other interested organizations to inform
6 beneficiaries regarding the current availability of low-cost infertility care and gamete
7 cryopreservation services at military treatment facilities for active-duty military personnel under
8 Tricare (Directive to Take Action); and be it further
9

10 RESOLVED, That our AMA work with the American Society for Reproductive Medicine (and the
11 American College of Obstetricians and Gynecologists (ACOG) and the American Urological
12 Association (AUA)) and other interested organizations to encourage Tricare to fully cover
13 infertility diagnosis and treatment for active-duty military personnel and others covered by
14 Tricare (Directive to Take Action); and be it further
15

16 RESOLVED, That our AMA work with the American Society for Reproductive Medicine (and
17 ACOG and AUA) and other interested organizations to encourage Tricare to fully cover gamete
18 preservation prior to deployment for active-duty military personnel (Directive to Take Action);
19 and be it further
20

21 RESOLVED, That our AMA report back on this issue at the 2019 Interim Meeting. (Directive to
22 Take Action)

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

Received: 10/11/18

References:

- 1 "By the Numbers: Women in the U.S. Military," by CNN.com on 1/24/13, accessed at:
<http://www.cnn.com/2013/01/24/us/military-women-glance/> on 10/25/15
- 2 Department of Veterans Affairs, Office of Public Affairs, Fact Sheet, accessed at:
<http://www.va.gov/WOMENVET/docs/WomenVeteransPopulationFactSheet.pdf> on 10/25/15
- 3 "Health care for women in the military and women Veterans. Committee Opinion No 547. American College of Obstetricians and
Gynecologists. Obstet Gynecol 2012; 120:1538-42.
- 4 "Helping Wounded Vets Start Families" by Rebecca Sokol (ASRM President) in the Baltimore Sun on 10/18/15, accessed at:
<http://www.baltimoresun.com/news/opinion/oped/bs-ed-veterans-ivf-20151018-story.html> on 10/25/15
- 5 "Access to Infertility Care: Challenges and Potential Solutions", by Erin Kramer (ASRM staff), ASRM 10/8/18
- 6 AMA policy H-510.984 on "Infertility Benefits for Veterans" (below)

RELEVANT AMA POLICY

Infertility Benefits for Veterans H-510.984

1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.

Citation: CMS Rep. 01, I-16

Veterans Administration Health System H-510.991

Our AMA supports approaches that increase the flexibility of the Veterans Health Administration to provide all veterans with improved access to health care services.

Citation: (CMS Rep. 8, A-99; Reaffirmed: CMS Rep. 5, A-09)

Health Care for Veterans and Their Families D-510.994

Our AMA will: (1) work with all appropriate medical societies, the AMA National Advisory Council on Violence and Abuse, and government entities to assist with the implementation of all recommendations put forth by the President's Commission on Care for America's Wounded Warriors; and (2) advocate for improved access to medical care in the civilian sector for returning military personnel when their needs are not being met by resources locally available through the Department of Defense or the Veterans Administration.

Citation: (BOT Rep. 6, A-08; Reaffirmed: Sub. Res. 709, A-15)

Health Care Policy for Veterans H-510.990

Our AMA encourages the Department of Veterans Affairs to continue to explore alternative mechanisms for providing quality health care coverage for United States Veterans, including an option similar to the Federal Employees Health Benefit Program (FEHBP).

Citation: (Sub. Res. 115, A-00; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)

Ensuring Access to Care for our Veterans H-510.986

1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.

Citation: (Res. 231, A-14; Reaffirmation A-15; Reaffirmed: Sub. Res. 709, A-15)

Access to Health Care for Veterans H-510.985

Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.

Citation: Sub. Res. 111, A-15; Reaffirmed: CMS Rep. 06, A-17

Supporting Awareness of Stress Disorders in Military Members and Their Families H-510.988

Our AMA supports efforts to educate physicians and supports treatment and diagnosis of stress disorders in military members, veterans and affected families and continue to focus attention and raise awareness of this condition in partnership with the Department of Defense and the Department of Veterans Affairs.

Citation: Sub. Res. 401, A-10; Reaffirmed in lieu of: Res. 001, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 812
(I-18)

Introduced by: Craig A. Backs, MD, Delegate

Subject: ICD Code for Patient Harm From Payer Interference

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

1 Whereas, The harm to patients caused by delayed implementation of prescribed treatment or
2 compromise in treatments or testing prompted by payers that result in switching for reasons
3 other than efficacy or toxicity cannot be quantified because its role cannot be coded by our
4 current ICD system; and
5

6 Whereas, Other contributors to patient and public health harm are identified by the mining of
7 data from ICD administrative codes, including but not limited to infections, poisons, assaults,
8 insect bites, trauma, infections and lifestyle factors; therefore be it
9

10 RESOLVED, That our American Medical Association support the creation and implementation
11 of an ICD code(s) to identify administrator or payer influence that affects treatment and leads to
12 or contributes to, directly or indirectly, patient harm. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 10/10/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 813
(I-18)

Introduced by: Indiana

Subject: Direct Primary Care Health Savings Account Clarification

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

1 Whereas, Indiana law defines direct primary care (DPC) as: (1) agrees to provide primary care
2 health services to the individual patient for an agreed-upon fee and time; 2) does not bill any
3 third parties on a fee-for-service basis; 3) charges a periodic fee for services; and 4) may
4 charge a per-visit charge only if the charge is less than the monthly equivalent of the periodic
5 fee; and

6
7 Whereas, Health savings accounts (HSAs) are unusable for DPC memberships under current
8 Internal Revenue Code (IRC) provisions; and

9
10 Whereas, There is currently a bill in Congress, The Primary Care Enhancement Act (H.R. 6317),
11 which clarifies HSA provisions regarding DPC in the tax code. The bill states DPC is not a
12 health plan under IRC. DPC is a medical service and allows individuals with HSAs to pay for
13 DPC services with HSAs; therefore be it

14
15 RESOLVED, That our American Medical Association seek federal changes to the Internal
16 Revenue Code allowing health savings accounts to be used with direct primary care. (Directive
17 to Take Action)

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

Received: 10/09/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 814
(I-18)

Introduced by: Indiana

Subject: Prior Authorization Relief in Medicare Advantage Plans

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

1 Whereas, Medical providers and hospitals were successful in the 2018 Indiana legislative
2 session in getting some prior authorization (PA) relief through HEA 1143 (P.L.77-2018); and
3

4 Whereas, That bill addressed only PA hassles and inconsistencies in commercial health
5 plans; and
6

7 Whereas, The same hassles and burdensome PA requirements are routinely applied in
8 Medicaid and Medicaid managed care plans, as well as Medicare Advantage plans; and
9

10 Whereas, There is a need to request relief equally from all health plans; therefore be it
11

12 RESOLVED, That our American Medical Association support legislation that would apply the
13 following legislative processes and parameters to prior authorization (PA) for Medicaid and
14 Medicaid managed care plans and Medicare Advantage plans:

- 15 • Listing services that require a PA on a website.
- 16 • Notifying providers of any changes at least 45 days prior to change.
- 17 • Standardizing a PA request form.
- 18 • Not denying payment for PA that has been approved unless fraudulently obtained or
19 ineligible at time of service.
- 20 • Defining a consistent process for appeals and grievances, including to Medicaid and
21 Medicaid managed care plans (New HOD Policy); and be it further
22

23 RESOLVED, That our AMA apply these same legislative processes and parameters to PA for
24 Medicaid and Medicaid managed care plans and Medicare Advantage plans, to include:

- 25 • Medications already working when a patient changes health plans cannot be changed by
26 the plan without discussion and approval of the ordering physician.
- 27 • Minimizing PA requirements as much as possible within each plan.
- 28 • Making an easily accessible and reasonably responsive direct communication tool
29 available to resolve disagreements between plan and ordering provider. (New HOD
30 Policy)

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

Received: 10/09/18

RELEVANT AMA POLICY

Prior Authorization and Utilization Management Reform H-320.939

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.

2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.

Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18

Prescription Drug Plans and Patient Access D-330.910

Our AMA will explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the Centers for Medicare and Medicaid Services and other appropriate organizations to resolve them.

Citation: (Res. 135, A-14)

<https://policysearch.ama-assn.org/policyfinder/search/medicare%20advantage/relevant/1/>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 815
(I-18)

Introduced by: Indiana

Subject: Uncompensated Physician Labor

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

1 Whereas, Physicians increasingly are using an electronic medical record; and

2
3 Whereas, A much-touted part of that record is communication with the patient electronically, as
4 initiated either by the physician or the patient; and

5
6 Whereas, Patients are typically expecting a quick turnaround on questions they send, as well as
7 other information coming from the physician's office. This expectation is now becoming a quality
8 measure that forces physicians to log on and review messages in the evening and sometimes
9 on the weekends and holidays; and

10
11 Whereas, Patients can initiate a new communication at any time, with some patients messaging
12 multiple times a week; and

13
14 Whereas, It can be argued that instructions about lab results and complaints voiced in the office
15 should be covered by the salary paid for an office visit. However, new after-hour and weekend
16 messages from patients are typically not addressed in employment contracts from the standpoint
17 of compensation for those services to the physician. The result is uncompensated labor that can
18 run several hours a day and multiple days a week. This is unfair to the physician and contributes
19 to physician burnout and dissatisfaction with their practice situation; therefore be it

20
21 RESOLVED, That our American Medical Association adopt policy that physicians should be
22 compensated for reviewing and responding to new after-hour patient messages. (New HOD
23 Policy)

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

Received: 10/09/18

RELEVANT AMA POLICY

11.3.1 Fees for Medical Services

Physicians are expected to conduct themselves as honest, responsible professionals. They should be knowledgeable about and conform to relevant laws and should adhere to professional ethical standards and sound business practice. Physicians should not recommend, provide, or charge for unnecessary medical services. Nor should they make intentional misrepresentations to increase the level of payment they receive or to secure noncovered health benefits for their patients.

With regard to fees for medical services, physicians should:

(a) Charge reasonable fees based on the:

- (i) kind of service(s);
- (ii) difficulty or uniqueness of the service(s) performed;
- (iii) time required to perform the service(s);
- (iv) skill required to perform the service(s);
- (v) experience of the physician;
- (vi) quality of the physician's performance.

(b) Charge only for the service(s) that are personally rendered or for services performed under the physicians direct personal observation, direction, or supervision. If possible, when services are provided by more than one physician, each physician should submit his or her own bill to the patient and be compensated separately. When physicians have professional colleagues assist in the performance of a service, the physician may pay a reasonable amount for such assistance and recoup that amount through fees charged to the patient, provided the patient is notified in advance of the financial arrangement.

(c) Itemize separately charges for diagnostic, laboratory, or clinical services provided by other health care professionals and indicate who provided the service when fees for others' services cannot be billed directly to the patient, in addition to charges for the physician's own professional services.

(d) Not charge excessive fees, contingent fees, or fees solely to facilitate hospital admission. Physicians must not charge a markup or commission, or profit on services rendered by other health care professionals.

(e) Extend professional courtesy at their discretion, recognizing that it is not an ethical requirement and is prohibited in many jurisdictions.

[AMA Principles of Medical Ethics: II,VI](#)

Issued: 2016

Definition of "Usual, Customary and Reasonable" (UCR) H-385.923

1. Our AMA adopts as policy the following definitions:

- (a) "usual; fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee);
- (b) a fee is 'customary' when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and
- (c) a fee is 'reasonable' when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans.

2. Our AMA takes the position that there is no relationship between the Medicare fee schedule and Usual, Customary and Reasonable Fees.

Citation: (Res. 109, A-07; Appended: Res. 107, A-13)

Physician Choice of Practice H-385.926

Our AMA: (1) encourages the growth and development of the physician/patient contract; (2) supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.); (3) supports the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers. (This right may be limited by contractual agreement.) An accompanying responsibility of the physician is to provide to the patient adequate fee information prior to the provision of the service. In circumstances where it is not feasible to provide fee information ahead of time, fairness in application of market-based principles demands such fees be subject, upon complaint, to expedited professional review as to appropriateness; and (4) encourages physicians when setting their fees to take into consideration the out-of-pocket expenses paid by patients under a system of individually selected and owned health insurance.

Citation: BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: Sub. Res. 701, A-93; Reaffirmation A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: Sub. Res. 107, I-93; Res. 124, I-93; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmation A-96; Reaffirmation I-96; Reaffirmation A-97; Reaffirmation I-98; Reaffirmation A-99; Appended by Res. 127, A-98; Reaffirmed: CMS Rep. 6, A-99; Reaffirmation A-00; Reaffirmation A-00; Sub. Res. 116, I-00; Reaffirmation & Reaffirmed: Res. 217, A-01; Reaffirmation A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed in lieu of Res. 127, A-10; Reaffirmation I-13; Reaffirmation A-15; Reaffirmed: CMS Rep. 5, I-15; Reaffirmed: CMS Rep. 09, A-16; Reaffirmed: CMS Rep. 07, A-17

Payment for Physicians' Services H-385.990

Our AMA:

(1) Recognizes the validity of a pluralistic approach to third party reimbursement methodology and recognizes that indemnity reimbursement, as a schedule of benefits, as well as "usual and customary or reasonable" (UCR), have positive aspects which merit further study.

(2) Reaffirms its support for: (a) freedom for physicians to choose the method of payment for their services and to establish fair and equitable fees; (b) freedom of patients to select their course of care; and (c) neutral public policy and fair market competition among alternative health care delivery and financing systems.

(3) Reaffirms its policy encouraging physicians to volunteer fee information to patients and to discuss fees in advance of services, where feasible.

(4) Urges physicians to continue and to expand the practice of accepting third party reimbursement as payment in full in cases of financial hardship, and to voluntarily communicate to their patients through appropriate means their willingness to consider such arrangements in cases of financial need or other circumstances.

Citation: (CMS Rep. B, I-83; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 137, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: BOT Rep. 10, I-05; Reaffirmed in lieu of Res. 127, A-10)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 816
(I-18)

Introduced by: Indiana

Subject: Medicare Advantage Plan Inadequacies

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

1 Whereas, Advantage plans have been a popular choice for 19 million seniors because of lower
2 premium cost and the expectation that members were being given extra perks, such as gym
3 membership, vision and dental insurance; and
4

5 Whereas, Seniors are lured to these advantage plans by misinformation and confusing sales
6 techniques; and
7

8 Whereas, Administrative costs have run as high as 10 percent. In comparison, CMS administers
9 the traditional Medicare plan at a cost of 3 percent or less; and
10

11 Whereas, Inadequacies of the plan have produced poor service for some members with lower
12 quality scores due to difficulties with physical therapy and rehab services. The number of days
13 approved has tended to be too short and the extent of rehab services too limited. There has
14 also been a delay in nursing home placement for some members, resulting in a delay of hospital
15 discharge and an increase in hospital costs; therefore be it
16

17 RESOLVED, That our American Medical Association investigate the deficiencies of Medicare
18 Advantage plans, with the goal of improving nursing home, rehab and physical therapy benefits.
19 Full transparency about the cost and coverage of the plan, as well as communication about plan
20 limitations, should be required (Directive to Take Action); and be it further
21

22 RESOLVED, That our AMA issue an opinion on whether Medicare Advantage plans should be
23 limited to healthier seniors with both a short problem list and short medication list, and whether
24 there should be a cap on administrative costs for these plans. (Directive to Take Action)

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

Received: 10/09/18

RELEVANT AMA POLICY

<https://policysearch.ama-assn.org/policyfinder/search/medicare%20advantage/relevant/1/>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 817
(I-18)

Introduced by: Indiana

Subject: Increase Reimbursement for Psychiatric Services

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

Whereas, The number of Hoosiers with mental health disorders appears to be growing over time, and yet, it is more and more difficult to refer these patients to a psychiatrist because of low numbers of practicing psychiatrists in most Indiana communities and low reimbursement to psychiatrists. Some psychiatrists will not even see Medicare patients due to reimbursement issues; and

Whereas, Untreated or inadequately treated psychiatric disease increases the risk of hospitalization but also crime, arrest and incarceration. A significant portion of the homeless population has chronic psychiatric conditions that are not adequately treated; and

Whereas, Most developed nations have more psychiatrists per 100,000 population than the United States. Monaco has 41 psychiatrists per 100,000 population; Norway has 29.7 psychiatrists per 100,000 population, while Indiana has fewer than 9 per 100,000 with the lowest rate in Muncie. Fort Wayne has 4.2 psychiatrists per 100,000 population; therefore be it

RESOLVED, That our American Medical Association support increasing reimbursement for psychiatric services through direct funding adjustments or via the relevant specialties pursuing a coding change through the established CPT Editorial Panel process. (New HOD Policy)

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

Received: 10/09/18

RELEVANT AMA POLICY

Medical, Surgical, and Psychiatric Service Integration and Reimbursement H-345.983

Our AMA advocates for: (1) health care policies that insure access to and reimbursement for integrated and concurrent medical, surgical, and psychiatric care regardless of the clinical setting; and (2) standards that encourage medically appropriate treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients.

Citation: (Res. 135, A-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 6, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 818
(I-18)

Introduced by: Indiana

Subject: Drug Pricing Transparency

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

1 Whereas, Indiana has an increasing number of diabetic patients struggling to access
2 medications due to high costs; and
3

4 Whereas, The prices of insulin in Indiana and across the nation have increased exponentially
5 over the past two decades, including an increase of more than 1,000 percent in Humalog; and
6

7 Whereas, States have produced legislation aimed at tracking unreasonable price increases in
8 essential medications; therefore be it
9

10 RESOLVED, That our American Medical Association advocate to the U.S. Surgeon General for
11 federal legislation that investigates all drug pricing. (Directive to Take Action)

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

Received: 10/09/18

RELEVANT AMA POLICY

<https://policysearch.ama-assn.org/policyfinder/search/drug%20pricing/relevant/1/>.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 819
(I-18)

Introduced by: Michigan

Subject: Medicare Reimbursement Formula for Oncologists Administering Drugs

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

1 Whereas, Oncologists currently purchase chemotherapeutic agents for in-office administration
2 to patients and bill Medicare for the purchase cost plus an additional 6 percent of the cost of the
3 chemotherapeutic agent as reimbursement for the infusion or injection of said agent; and
4

5 Whereas, The 6 percent reimbursement becomes 4.3 percent with prompt pay discounts; and
6

7 Whereas, The time and attention required to administer one chemotherapeutic agent compared
8 to another has no relation to its cost; and
9

10 Whereas, The current Medicare reimbursement strategy poses financial risks to practices and
11 creates a perverse incentive to prescribe a newer, more expensive drug when an older, less
12 expensive drug may be equally effective; and
13

14 Whereas, It also drives up the medical costs of administering chemotherapy without adding
15 value; and
16

17 Whereas, The failings of the buy-and-bill system impact all oncologists, but small independent
18 practices shoulder the greater burden; and
19

20 Whereas, The very existence of small independent practices is threatened, and with it access to
21 care for many of our most vulnerable patients; and
22

23 Whereas, "Freeing oncologists from dependency on drug revenues while keeping outpatient
24 oncology viable requires a focus on reimbursement for services that are uncompensated or
25 undercompensated in the current system;" therefore be it
26

27 RESOLVED, That our American Medical Association amend policy H-55.994 by addition to read
28 as follows:
29

30 Coverage of Chemotherapy in Physicians' Offices H-55.994

31 The AMA: (1) supports adequate reimbursement for outpatient oncology office
32 visits that recognizes the complexity of the patient's care management; and (2)

33 advocates that physicians who bill any third party payer for administering
34 chemotherapy should ensure that the services billed for are described adequately
35 and fully on the appropriate claim form and that the chemotherapy descriptors and
36 code numbers provided by CPT are utilized (Modify Current HOD Policy); and be it
37 further

- 1 RESOLVED, That our AMA advocate for a change to the Medicare reimbursement
- 2 formula such that the costs of chemotherapeutic agents are covered, plus an unrelated
- 3 flat fee to cover the cost of the infusion or injection of said agents. (Directive to Take
- 4 Action)

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

Received: 10/10/18

RELEVANT AMA POLICY

Coverage of Chemotherapy in Physicians' Offices H-55.994

The AMA advocates that physicians who bill any third party payer for administering chemotherapy should ensure that the services billed for are described adequately and fully on the appropriate claim form and that the chemotherapy descriptors and code numbers provided by CPT are utilized.

Citation: (CMS Rep. C, I-82; Reaffirmed: CLRPD Rep. A, I-92; Modified and Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 820
(I-18)

Introduced by: Michigan

Subject: Ensuring Quality Health Care for Our Veterans

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

Whereas, *USA Today* has reported on seriously deleterious physician hiring practices in the Veterans Health Administration; and

Whereas, These deleterious hiring practices include subjecting our nations' veterans to care by physicians who have faced dozens of malpractice cases, and who have been sanctioned and, in some cases, have lost their licenses to practice in at least one state; and

Whereas, The U.S. Government Accountability Office has recently reported that the U.S. Department of Veterans Affairs failed to report 90 percent of potentially dangerous medical providers in recent years to a national database; and

Whereas, *USA Today* has found that oversight of the Veteran's Administration is so lax that the Veterans Administration had no idea how many medical workers had been reported or if they had been reported at all; and

Whereas, The U.S. Government Accountability Office has discovered that at one facility, officials failed to report six providers to the national practitioner database because the officials were unaware that they had been delegated responsibility for reporting; and

Whereas, Patients receiving care in non-Veterans Health Administration institutions would not be subjected to similar substandard care; therefore be it

RESOLVED, That our American Medical Association amend policy H-510.986, "Ensuring Access to Care for our Veterans," by addition to read as follows:

Ensuring Access to Safe and Quality Care for our Veterans H-510.986

1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.

2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.

3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.

4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the

1 registry be made available to the veterans in their community and the local Veterans
2 Administration.

3 5. Our AMA will strongly advocate that the Veterans Health Administration and
4 Congress develop and implement necessary resources, protocols, and
5 accountability to ensure the Veterans Health Administration recruits, hires and
6 retains first-rate, competent, and ethical physicians and other health care
7 professionals to deliver the safe, effective and high-quality care that our veterans
8 have been promised and are owed.

9 6. Our AMA will engage the Veterans Health Administration in dialogue on
10 accreditation practices by the Veterans Health Administration to assure they are
11 similar to those of hospitals, state medical boards, and insurance companies.
12 (Modify Current HOD Policy)

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

Received: 10/10/18

RELEVANT AMA POLICY

Ensuring Access to Care for our Veterans H-510.986

1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.

Citation: (Res. 231, A-14; Reaffirmation A-15; Reaffirmed: Sub. Res. 709, A-15)

Expansion of US Veterans' Health Care Choices H-510.983

1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans.
2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program.
3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways.
4. Our AMA will support consolidation of all the VA community care programs.
5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care.
6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission.
7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days.

8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care.

9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.

10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program.

Citation: CMS Rep. 06, A-17

Fixing the VA Physician Shortage with Physicians D-510.990

1. Our AMA will work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities.

2. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility.

3. Our AMA will work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans.

Citation: Res. 1010, A-16

Support for VA Health Services for Women Veterans H-510.981

Our AMA recognizes the disparity in access to care for women veterans, and encourages research to address this populations specific needs to improve patient outcomes.

Citation: Res. 825, I-17

Access to Health Care for Veterans H-510.985

Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.

Citation: Sub. Res. 111, A-15; Reaffirmed: CMS Rep. 06, A-17

Health Care for Veterans and Their Families H-510.989

Our AMA supports the recommendations of the President's Commission on Care for America's Wounded Warriors report "Serve, Support, Simplify."

Citation: BOT Rep. 6, A-08; Reaffirmed: BOT Rep. 09, A-18

Health Care for Veterans and Their Families D-510.994

Our AMA will: (1) work with all appropriate medical societies, the AMA National Advisory Council on Violence and Abuse, and government entities to assist with the implementation of all recommendations put forth by the President's Commission on Care for America's Wounded Warriors; and (2) advocate for improved access to medical care in the civilian sector for returning military personnel when their needs are not being met by resources locally available through the Department of Defense or the Veterans Administration.

Citation: (BOT Rep. 6, A-08; Reaffirmed: Sub. Res. 709, A-15)

Health Care Policy for Veterans H-510.990

Our AMA encourages the Department of Veterans Affairs to continue to explore alternative mechanisms for providing quality health care coverage for United States Veterans, including an option similar to the Federal Employees Health Benefit Program (FEHBP).

Citation: (Sub. Res. 115, A-00; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)

Veterans Administration Health System H-510.991

Our AMA supports approaches that increase the flexibility of the Veterans Health Administration to provide all veterans with improved access to health care services.

Citation: (CMS Rep. 8, A-99; Reaffirmed: CMS Rep. 5, A-09)

Requiring The Joint Commission to Conduct Root-Cause Analysis to Determine How its Surveys Allowed Veterans Administration Hospitals to Cause Delay in Treatment and Harm Veterans D-510.991

Our AMA supports The Joint Commission making public its findings following its resurveying of Veterans Health Administration (VHA) facilities to ensure quality of care and patient safety.

Citation: (Sub. Res. 709, A-15)

Budgetary and Management Needs of the Veterans Health Administration H-510.995

Our AMA urges Congress and the President to provide the VHA: (1) with funding sufficient to allow its hospitals and clinics to provide proper care to the patients the VHA is mandated to treat; and (2) with maximum flexibility in eliminating unneeded or duplicative services and in closing clinics or hospitals.

Citation: (BOT Rep. EE, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 821
(I-18)

Introduced by: Michigan

Subject: Direct Primary Care and Concierge Medicine Based Practices

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

1 Whereas, The current medical economic environment is creating many changes in the
2 configurations of medical practices, as well as impacting how physicians decide whether to
3 group together or work alone; and
4

5 Whereas, The hassle factors associated with accepting insurances represents a major cost to
6 practices and causes frustration for physicians; and
7

8 Whereas, Physicians have no control over which insurances their patients subscribe to; and
9

10 Whereas, Physicians have no control over the divergent requirements of each individual
11 insurance company; and
12

13 Whereas, An increasing subset of physicians have chosen to no longer accept insurance;
14 instead, choosing to pursue rapidly growing models of primary care referred to as direct primary
15 care and concierge medicine; and
16

17 Whereas, Some medical practices charge a membership fee which allows them to offer a
18 complete range of primary care services, including those that insurance coverages do not allow;
19 and
20

21 Whereas, Current Internal Revenue Service (IRS) rules and interpretations present barriers that
22 impede individual participation in direct primary care and concierge medicine models; and
23

24 Whereas, These impediments include restrictions and prohibitions on the use of funds from
25 health savings accounts to pay for certain fees attributed to membership in these care delivery
26 models, as well as prohibiting an individual who has an arrangement with a direct primary care
27 practice from contributing to a health savings account; therefore be it
28

29 RESOLVED, That our American Medical Association actively lobby for revision to the U.S. tax
30 code to allow funds from health savings accounts to be used for concierge medicine and direct
31 primary care without incurring a tax penalty. (Directive to Take Action)

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

Received: 10/10/18

RELEVANT AMA POLICY

Direct Primary Care H-385.912

Our AMA supports: (1) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (2) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.

Citation: Res. 103, A-16; Appended: Res. 246, A-18; Reaffirmation: A-18

Reference Committee K

BOT Report(s)

12 Information Regarding Animal-Derived Medications

CSAPH Report(s)

01* Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals

02* FDA Expedited Review Programs and Processes

Resolution(s)

901 Support for Preregistration in Biomedical Research

902 Increasing Patient Access to Sexual Assault Nurse Examiners

903 Regulating Front-of-Package Labels on Food Products

904 Support for Continued 9-1-1 Modernization and the National Implementation of Text-to-911 Service

905 Support Offering HIV Post Exposure Prophylaxis to all Survivors of Sexual Assault

906 Increased Access to Identification Cards for the Homeless Population

908 Increasing Accessibility to Incontinence Products

911 Regulating Tattoo and Permanent Makeup Inks

912 Comprehensive Breast Cancer Treatment

913 Addressing the Public Health Implications of Pornography

914 Common Sense Strategy for Tobacco Control and Harm Reduction

915* Mandatory Reporting

916* Ban on Tobacco Flavoring Agents with Respiratory Toxicity

917* Protect and Maintain the Clean Air Act

918* Allergen Labeling on Food Packaging

919* Opioid Mitigation

920* Continued Support for Federal Vaccination Funding

921* Food Environments and Challenges Accessing Healthy Food

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-I-18

Subject: Information Regarding Animal-Derived Medications (Resolution 515-A-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 INTRODUCTION

2
3 Resolution 515-A-18, "Information Regarding Animal Derived Medications," introduced by the
4 Michigan Delegation and referred by the House of Delegates (HOD) asked:

5
6 That our American Medical Association (AMA): (1) Support efforts to improve cultural
7 awareness pertaining to the use of animal-derived medications when considering different
8 prescription options. (2) Encourage the U.S. Food and Drug Administration to make available
9 to the public an easily accessible database that identifies medications containing ingredients
10 derived from animals.

11
12 Some chemical products used as inactive excipients for prescription drugs, as well as some active
13 prescription medications and also some surgical implants, dressings, and mesh, are derived from
14 animal sources. The consumption or use of such products may be objectionable to certain religions
15 or based on consumer choice. The objective of this report is to summarize the issue and current
16 evidence related to animal-derived components of medical products.

17 BACKGROUND

18
19
20 Some religious faiths forbid the consumption or use of certain animals and substances derived from
21 them. Additionally, individuals who adhere to a vegetarian or vegan diet may prefer to avoid
22 animal-derived medical products. Individuals who want to avoid animal-derived substances for
23 religious or cultural reasons may inquire about the origin or source of the ingredients in their
24 medical products for informed decision-making regarding treatment with the product. Frequently,
25 however, the information regarding ingredients or composition in medications is difficult to obtain
26 by physicians, pharmacists, and patients.¹

27
28 Many pharmaceutical products (both active and inactive ingredients used in capsules, tablets,
29 injections, vaccines, creams) and surgical products (implants, wound dressings, surgical mesh)
30 contain ingredients derived from animal sources. Animal-derived ingredients (ADIs) are used in
31 many medical fields and cover an array of products usually at minimal concentrations.¹ However, a
32 substantial percentage of patients and physicians are unaware that some medications and medical
33 products contain animal products;² one survey indicated that 84% of patients and 70% of
34 physicians were unaware that several medications contain ADIs. Additionally, 70% of physicians
35 thought it was important to inform patients who might object if such medications are prescribed.³
36 Some authors have even suggested obtaining informed consent before using animal-derived
37 products.¹

POLICY AND LAW

The U.S. Pharmacopeial Convention is a private, nongovernmental organization that publishes the United States Pharmacopeia (USP) and the National Formulary (NF) as official compendia, collectively called the USP-NF. The Federal Food, Drug and Cosmetic Act (FFDCA) expressly recognizes the USP quality standards for medicines.⁴ Although much of the USP-NF is legally enforceable, the USP chapters numbered above <999> are general information and generally do not contain any mandatory requirements, but can include recommendations that may help a firm meet the requirements of current good manufacturing processes (CGMPs) as defined by the U.S. Food and Drug Administration (FDA).⁵

FDA Guidance regarding CGMP includes recommendations and precautions when manufacturing ADIs to ensure that contamination by pathogenic agents does not occur. No guidance regarding labeling of ADIs could be located. Although the FDA does have a database that provides information on inactive ingredients present in FDA-approved drug products, its main purpose is to aid industry in drug development; once an inactive ingredient is part of the formulation for an approved drug product, it is no longer considered new and may require less extensive review when used again. The database includes no information regarding the source of the ingredient.⁶

USP-NF general chapter <7> “Labeling” details the requirements for the labeling of active ingredients in pharmaceutical products. No discussion of ingredient source is included. It is noted, however, that many monographs have unique labeling requirements that should be used consistently. USP-NF informational chapter <1091> “Labeling of Inactive Ingredients” states that all ingredients should be disclosed for all medications. The information can be found on the package or insert of a prescription drug and on the drug facts label on the outside of the box for over-the-counter drugs. No requirement exists for a manufacturer to declare how an ingredient is sourced. Additionally, the Code of Federal Regulations calls for all ingredients to be listed, but inactive ingredients are exempt from provisions on misbranding, including some that relate to false or misleading labeling.⁷

CULTURAL CONSIDERATIONS

Some religious groups avoid products from certain animals and many patients have strong religious convictions and beliefs. Vegetarians do not consume foods either directly obtained or using products from the slaughter of an animal. Vegans do not consume any foods originating from animals.

Several investigators have surveyed worldwide religious leaders for their opinions regarding the acceptability of certain medical products, both medications and surgical implants/dressings/mesh, for their religions.^{1,8-11} The surveys generally focused on the six largest religions worldwide and reported varied practices. Many Hindus and Sikhs do not approve of the use of bovine- or porcine-derived products and also follow vegetarian diets. Many who practice Islam or Judaism do not accept the use of porcine-derived products. No principle in Buddhism prohibits the use of animal-derived medical products; however, many members of one of the two major branches follow a vegetarian diet. Most Christians, other than those who follow vegetarian or vegan diets, do not have restrictions. Although Jehovah’s Witnesses refuse blood transfusions, all other medical related products and decisions are at the discretion of the patient and physician. Notably, leaders from all surveyed religions stated that the use of animal-derived medical products would be accepted in the absence of any other alternative or in emergency situations. In difficult situations, religious leaders can also be contacted for guidance.

OTHER CONSIDERATIONS

Various communication practices for patient-directed medication information including readability, container labeling (font, format, and organization), information content length, and supplementary medication instructions have been described, but do not address ingredient lists and source.¹²

Reports of medication non-adherence or discontinuation because of ADI avoidance exist.¹³ Some authors have suggested that when healthcare professionals listen to patients' cultural beliefs, actively involve them in medication prescribing decisions, and take their views and preferences into account, adherence is more likely.¹⁴

Nevertheless, ADI information is inconsistently reported, difficult to obtain, and sometimes incorrect.^{2,15} Also noteworthy is the fact that excipients and inactive ingredients likely differ between branded and generic forms of medications; therefore, knowledge of the ingredients in a particular branded medication will not guarantee knowledge of generic versions. Some drugs, especially those produced in gelatin capsules, may be available in alternative formulations that do not contain ADIs. Literature discussing clinical decision support systems for physicians and drug databases used by pharmacists has not addressed the issue of ADIs and the inclusion of relevant ADI information. If the source of ADIs, or the fact that an ingredient is an ADI, were required labeling for manufacturers, the potential would exist for this information to be included in the datasets used by clinical decision support systems and drug databases downstream.

PROBLEM MEDICAL PRODUCTS

Both active and inactive pharmaceutical ingredients as well as implants, dressings, and mesh used in surgery can contain ADIs. Some of the more common examples of these ADIs are included in discussion below.

Active Ingredients

The following are examples of products that contain an active ingredient derived from an animal source:

- Conjugated estrogens (Premarin) are derived from the urine of pregnant mares.¹⁶
- Low molecular weight heparin is porcine-derived.¹⁷
- Corticotropin is obtained from porcine pituitary gland.¹⁸
- Hyaluronidase is derived from crude extracts of ovine or bovine testicular tissue.¹⁹
- Pancreatin (also known as pancreatic enzymes, pancrelipase) is bovine derived.²⁰

The product information for these medications indicates that they are animal-derived. However, for some, the information is difficult to locate, often only becoming obvious because of a statement in the "allergy" or "contraindications" section (e.g., This medication is contraindicated in patients with sensitivity to proteins of porcine origin.).

Inactive Ingredients

In a recent review, the use of ADIs in the 100 most commonly prescribed medications in primary care in the United Kingdom found that 74 contained at least one of the three most common excipient ADIs used – gelatin, lactose, and magnesium stearate.¹⁵ Of these 74 products, 42 provided no indication of the presence of an ADI, and 2 products incorrectly stated that no animal content was contained in the product.¹⁵

Gelatin is a generic term for a mixture of purified protein fractions obtained by hydrolysis of animal collagen obtained from bovine or porcine bone, or from bovine, porcine, or fish skin. It is most frequently used in the capsules of medications. Due to the demand for gelatin-free medication, the production of vegetarian capsules made from hypromellose has expanded, and the use of bioreactors utilizing “cellular agriculture” to create purified proteins that are assembled into collagen and then made into gelatin is becoming popular; but animal-derived gelatin is still used commonly.^{2,21}

Lactose is a natural disaccharide present in the milk of most mammals and is traditionally extracted from milk using bovine rennet. Some manufacturers now use a vegetarian process instead of bovine rennet to extract lactose from bovine milk, but this has caused confusion about suitability for those who avoid bovine products.¹⁵ Lactose is widely used as a filler and diluent in tablets and capsules and is also used as a diluent in dry-powder inhalations, in the preparation of sugar-coating solutions, and in some injections.^{2,15}

Stearic acid, utilized as magnesium stearate in products, is a fatty acid sourced from rendered bovine, porcine, or ovine fat or produced from vegetable matter. It is primarily used as a lubricant in capsule and tablet manufacture and improves the solubility of some medications. If the source of the magnesium stearate is not indicated on a drug label, whether or not it is an ADI is unknown and difficult to determine.²

Vaccines

Materials used in the production of some vaccines, e.g., excipients or nutritional supplements for cell cultures, are ADIs. These include gelatin, trypsin (usually bovine sourced), and bovine serum or albumin.²² Religious scholars distinguish between the use of ADIs in oral or non-oral medications and have issued rulings or waivers that allow use of non-oral medications containing ADIs, such as vaccines.² Despite this distinction, reports persist of concern with ADIs in vaccines.¹⁵

Surgical Sutures, Implants, Dressings, and Mesh

The use of synthetic and biological products is widespread in surgeries, and the use of a biologic product that is prohibited or is sacred in a surgical setting is a concern.^{8,10} Sutures used to close wounds or surgical incisions can contain animal-derived ingredients. A recent study confirmed the frequent use of ADIs, such as collagen membrane, collagen gel, fibrin glue, fibrinogen, aprotinin and some types of chitosan culture media and scaffold, in various arthroscopy products.¹⁰ Allograft and xenograft mesh products have also been cited as problematic for patients with issues related to the use of ADIs.¹¹ Authors encourage surgeons to know the source of the products they use as well as the basic requirements of their patient’s faith, possibly even gaining informed consent before the use of animal-derived surgical implants.^{8,11}

CURRENT AMA POLICY

No AMA policy addresses this issue.

CONCLUSION

Several medication ingredients, both active and inactive, and surgical products contain ingredients derived from animal sources. Patients may have strong religious convictions and cultural beliefs leading them to object to using medical products with animal-derived ingredients.

1 It has been documented that physicians may have a hard time determining the origin of ingredients
2 because the information is inconsistently reported, difficult to obtain, and sometimes incorrect.
3 Many times, reading the list of ingredients of a medical product will not clarify if the product
4 contains any animal-derived ingredients or components. Additionally, the products can vary in
5 regard to ADIs based on the manufacturer, and between brand name and generic versions.

6
7 Because no requirement exists for a manufacturer to declare how an ingredient is sourced on label
8 information, this information is not present in clinical decision support systems for physicians and
9 drug databases. Including additional information, such as the presence of ADIs and their source, in
10 the ingredients lists on drug labels and in product information would be beneficial because this
11 information could then be included in information systems used by clinicians and would be more
12 accessible to patients.

13
14 **RECOMMENDATION**

15
16 The Board of Trustees recommends the following be adopted in lieu of Resolution 515-A-18, and
17 the remainder of the report be filed:

18
19 **Animal-Derived Ingredients**

20
21 **Our AMA:**

- 22
23 1. Urges the U.S. Food and Drug Administration to require manufacturers to include all
24 ingredients and components present in medical products on the product label, including
25 both active and inactive ingredients, and denote any derived from an animal source. (New
26 HOD Policy)
27
28 2. Encourages cultural awareness regarding patient preferences associated with medical
29 products containing active or inactive ingredients or components derived from animal
30 sources. (New HOD Policy)

Fiscal Note: Less than \$500

REFERENCES

1. Eriksson A, Burcharth J, Rosenberg J. Animal derived products may conflict with religious patients' beliefs. *BMC Medical Ethics*. 2013;14(1):48.
2. Implications of religious and cultural beliefs on selection of medicines. *Drug and Therapeutics Bulletin*. 2016;54(4):45-48.
3. Sattar SP, Ahmed MS, Madison J, et al. Patient and physician attitudes to using medications with religiously forbidden ingredients. *Ann Pharmacother*. 2004;38(11):1830-1835.
4. 21 U.S.C. ch. 9 § 301.
5. U.S. Food and Drug Administration. Current Good Manufacturing Practice (CGMP) Regulations. 2018; <https://www.fda.gov/Drugs/DevelopmentApprovalProcess/Manufacturing/ucm090016.htm>. Accessed July 23, 2018.
6. U.S. Food and Drug Administration. Inactive Ingredient Search for Approved Drug Products: Frequently Asked Questions. 2017; <https://www.fda.gov/drugs/informationondrugs/ucm080123.htm>. Accessed July 23, 2018.
7. 21 C.F.R. pt. 201
8. Easterbrook C, Maddern G. Porcine and bovine surgical products: Jewish, Muslim, and Hindu perspectives. *Arch Surg*. 2008;143(4):366-370; discussion 370.
9. Fitzpatrick SJ, Jordens CF, Kerridge IH, et al. Religious perspectives on the use of psychopharmaceuticals as an enhancement technology. *J Relig Health*. 2014;53(5):1440-1455.
10. Goyal D, Goyal A, Brittberg M. Consideration of religious sentiments while selecting a biological product for knee arthroscopy. *Knee Surg Sports Traumatol Arthrosc*. 2013;21(7):1577-1586.
11. Jenkins ED, Yip M, Melman L, Frisella MM, Matthews BD. Informed consent: cultural and religious issues associated with the use of allogeneic and xenogeneic mesh products. *J Am Coll Surg*. 2010;210(4):402-410.
12. Mullen RJ, Duhig J, Russell A, Scarazzini L, Lievano F, Wolf MS. Best-practices for the design and development of prescription medication information: A systematic review. *Patient Educ Couns*. 2018;101(8):1351-1367.
13. Sattar SP, Shakeel Ahmed M, Majeed F, Petty F. Inert medication ingredients causing nonadherence due to religious beliefs. *Ann Pharmacother*. 2004;38(4):621-624.
14. National Collaborating Centre for Primary C. National Institute for Health and Clinical Excellence: Guidance. *Medicines Adherence: Involving Patients in Decisions About Prescribed Medicines and Supporting Adherence*. London: Royal College of General Practitioners (UK); 2009.
15. Tatham KC, Patel KP. Suitability of common drugs for patients who avoid animal products. *BMJ : British Medical Journal*. 2014;348.
16. Pfizer Inc. Premarin Product Label. <http://labeling.pfizer.com/showlabeling.aspx?id=131>. Accessed July 26, 2018.
17. Amin A. Therapeutic Interchange of Parenteral Anticoagulants: Challenges for Pharmacy and Therapeutics Committees. *Pharmaceuticals*. 2011;4(11):1475-1487.
18. Acthar Gel Product Information. https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022432s000lbl.pdf. Accessed July 26, 2018.
19. Dunn AL, Heavner JE, Racz G, Day M. Hyaluronidase: a review of approved formulations, indications and off-label use in chronic pain management. *Expert Opin Biol Ther*. 2010;10(1):127-131.
20. Creon Product Information. https://www.accessdata.fda.gov/drugsatfda_docs/label/2009/020725s000lbl.pdf. Accessed July 26, 2018.
21. Dance A. Engineering the animal out of animal products. *Nat Biotechnol*. 2017;35(8):704-707.
22. Grabenstein JD. What the world's religions teach, applied to vaccines and immune globulins. *Vaccine*. 2013;31(16):2011-2023.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-I-18

Subject: Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals

Presented by: Robyn F. Chatman, MD, MPH, Chair

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

INTRODUCTION

Policy D-515.980, “Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals,” asks:

That our American Medical Association study recent domestic violence data and the unique issues faced by the LGBTQ population.

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases from January 2008 to June 2018 using the search terms “gay,” “lesbian,” “bisexual,” “transgender,” “queer,” “LGBT,” and “LGBTQ” in conjunction with the terms “intimate partner violence,” “domestic violence,” and “partner abuse.” Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by non-profit and advocacy organizations were also reviewed for relevant information.

CURRENT AMA POLICY

AMA Policy H-160.991, “Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations,” recognizes that the physician’s nonjudgmental recognition of patients’ sexual orientation, sexual behaviors, and gender identities enhances their ability to render optimal patient care.” Furthermore, this policy states that our AMA will collaborate with partner organizations to educate physicians on how individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence (IPV), and how sexual and gender minorities present with IPV differ from their cisgender, heterosexual peers and the fact they may have unique complicating factors. The AMA will also promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ survivors of domestic violence (D-515.980, “Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals”). AMA Policy H-515.965, “Family and Intimate Partner Violence,” broadly addresses the physician’s role in IPV and is not specific to patients of a certain gender or sexual orientation. The AMA encourages physicians to routinely inquire about the IPV histories of their patients and upon identifying patients experiencing abuse or threats from intimates, assess and discuss safety issues, and refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible.

BACKGROUND

IPV describes physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner.¹ Examples of intimate partners include current or former spouses, boyfriends or girlfriends, dating partners, or sexual partners. While IPV can occur between heterosexual or same-sex couples and does not require sexual intimacy, much of the effort to address this public health problem has focused on heterosexual women even though other populations experience IPV at similar rates.

EPIDEMIOLOGY OF IPV IN THE LGBTQ POPULATION

Little is known about the national prevalence of IPV in the LGBTQ population in the United States.² While a number of small-scale studies have examined violence in the LGBTQ population, the research is difficult to interpret and generalize due to the variability of methodologies utilized, which include different measures of IPV and different time frames to which the violence corresponds (i.e., past year, lifetime).²⁻⁵ In addition, researchers have had difficulty recruiting samples that are representative of the LGBTQ population, so the majority of studies have been conducted with small convenience samples.²⁻⁴ A further complication with the research involves the failure to distinguish between sexual activity (behavior) and sexual identity.³ These factors have resulted in inconsistent findings in terms of victimization rates among these groups.^{4,5} For example, a systematic review on IPV in self-identified lesbians found that victimization prevalence in studies ranged between 10 to 51 percent.³

In 2010, the Centers for Disease Control and Prevention's (CDC) National Intimate Partner and Sexual Violence Survey (NISVS), provided the first national-level data on the prevalence of intimate partner violence, sexual violence, and stalking among the lesbian, gay, and bisexual (LGB) population by self-reported sexual orientation (transgender individuals were not included in this study).² The pattern of results suggests that individuals who self-identify as LGB experience an equal or greater likelihood of experiencing sexual violence, stalking, and intimate partner violence compared with self-identified heterosexuals. The survey found that 61 percent of bisexual women and 44 percent of lesbian women reported experiencing rape, physical violence, and/or stalking within the context of an intimate partner relationship at least once during their lifetime versus 35 percent of heterosexual women.² For men, the lifetime prevalence of intimate partner violence was 37 percent for bisexual men, 29 percent for heterosexual men, and 26 percent for gay men.²

Limited data is available regarding IPV in transgender and genderqueer people as researchers tend to offer only binary gender identify categories. However, the available evidence suggests these populations are even more vulnerable to LGBTQ-specific IPV tactics.⁴ Findings of lifetime IPV among people who are transgender range from 31 percent to 50 percent.⁶ One study directly compared the lifetime prevalence of IPV among transgender and cisgender people and found that 31 percent of transgender people and 20 percent of cisgender people had ever experienced IPV or dating violence.⁷

DISCUSSION

Risk Factors

A number of factors can put LGBTQ individuals at increased risk for IPV victimization and perpetration and many of these risk factors are similar to those among heterosexual individuals. Risk factors for IPV victimization include:

racial minority status, lower socioeconomic status, younger age, deaf or hard of hearing, substance use/abuse/dependence, low self-esteem, risky sexual behavior, victim blaming attitudes, lack of power in relationships, attachment anxiety, HIV positive status, child abuse, witnessing IPV as a child, victimization in peer networks, psychological and physical health problems, history of sex work, and history of incarceration.⁵

Risk factors for IPV perpetration include:

interpersonal problems, greater conformity to masculine norms, less secure attachments, greater psychological distress, more substance use/abuse/dependency, high need for control, low socioeconomic status, less education, racial minority status, low self-esteem, more stress, HIV positive status, unprotected sexual intercourse, child abuse, exposure to IPV as a child, disordered personality characteristics, and poor relationship quality.⁵

Identity Abuse Tactics

While some research on the abusive partners' use of physical and psychological abuse may be generalizable across communities, unique aspects to LGBTQ relationships are believed to exist. This includes identity abuse (IA), which are abuse tactics that leverage systematic oppression to harm an individual.⁸ IA tactics of IPV leverage heterosexism and cissexism against LGBTQ survivors.⁸ These tactics including threatening to disclose a partner's LGBTQ status without their consent. This can result in fear of loss of children, employment, housing, or relationships with family and friends.⁴ Another IA tactic includes undermining, attacking, or denying a partner's identity as an LGBTQ person.⁸ Examples include accusing a partner of being straight, questioning their authenticity, or being prevented from expressing their gender identity. Other IA tactics include using slurs or derogatory language regarding the partner's sexual orientation or gender identity and isolating survivors from the LGBTQ community.^{8,9} These tactics are also used in threatening partners who seek help.

In examining the prevalence of IA in the LGBTQ community, nearly 17 percent of the sample (n=734) of sexual minority adults reported experiencing at least one form of IA in the last year and 40 percent reported experiencing IA at some point in adulthood.⁸ In terms of gender, women (43 percent) experienced significantly more exposure to IA in adulthood than men (24 percent). Transgender or gender non-confirming participants (50 percent) reported higher rates of IA in adulthood than their cisgender counterparts.⁸ In terms of sexual orientation, queer-identified participants (49 percent) and bisexual participants (48 percent) had the highest rates of IA in adulthood (nearly 50 percent) compared with their lesbian (35 percent) and gay (26 percent) counterparts.⁸

Health Outcomes

IPV is associated with poor physical and mental health outcomes. For example, in a study (n=817) of men who have sex with men there was a significant relationship between a range of health problems and IPV.¹⁰ Abused men were more likely than non-abused men to report problems such as hypertension, heart disease, obesity, smoking-related illness and, to some extent, sexually transmitted infections.¹⁰ Men in abusive relationships were more likely to report depression or other mental health problems, and to engage in unhealthy behaviors such as substance abuse, combining drugs with sex, or unprotected sex.¹⁰ Another study of LGBT young adults (n=172) found that being a victim of IPV was associated with concurrent sexual risk taking and prospective mental health outcomes, but was not associated with substance abuse.¹¹

BARRIERS TO SEEKING HELP

Screening

The medical community has been criticized for neglecting members of the LGBTQ population in their efforts to respond to the problem of IPV.¹² However, research is lacking on the best practices for identifying LGBTQ survivors of IPV.¹³ It is unclear if existing tools are relevant to LGBTQ survivors, though limited research suggests that they are and that changes in wording and additional questions could improve their relevancy.¹³

U.S. Preventive Services Task Force (USPSTF). The USPSTF recommends that clinicians screen women of childbearing age for IPV, such as domestic violence, and provide or refer women who screen positive to intervention services (B recommendation).¹⁴ In making this recommendation, the USPSTF examined the accuracy of available screening tests, the effectiveness of early detection through trials examining interventions, the potential harms of screening and interventions, and the estimated magnitude of the net benefit. The USPSTF, in discussing clinical considerations, recognized that a significant body of evidence is lacking for other populations, especially men. It was noted that research is needed in all areas related to screening and treatment in men, as well as reporting, safety, community linkages and supports, legal ramifications, and cultural aspects.¹⁴ The USPSTF is in the process of updating this recommendation, but the draft statement that has been posted indicates that research gaps still exist. However, the draft recommendation does not specifically note the gaps in research related to the LGBTQ population.¹⁵

Futures Without Violence has collaborated with a number of organizations to develop materials that are specifically for LGBTQ people. The “Caring Relationships, Healthy You” safety cards and poster are survivor-centered tools that are useful conversation starters for health care providers who are doing universal education around healthy relationships and assessing for IPV.¹⁶

Interventions and Services

In addition to effective screening tools, more research is needed to determine the interventions that are effective in reducing the harms of IPV in the LGBTQ population. For women of childbearing age, effective interventions include ongoing support services focused on counseling and home visits, those that address multiple risk factors (not just IPV), or include parenting support for new mothers.¹⁵ However, IPV interventions should be culturally relevant, tailored to specific groups, and evaluated within those groups.¹⁷

There is limited knowledge about LGBTQ IPV in the general community and limited resources are available to support LGBTQ survivors.⁹ When LGBTQ individuals attempt to access IPV services their options are often severely limited.¹² When services are provided to LGBTQ IPV survivors, the lack of cultural competency and informed support can re-traumatize the victim.¹² Gaps in services include: limited LGBTQ-friendly health care services, lack of adequate training at agencies around LGBTQ issues, limited medical access, and intake forms that are not LGBTQ friendly.⁹ A 2010 study by the National Coalition of Anti-Violence Programs surveyed domestic violence agencies, sexual assault centers, prosecutors’ offices, law enforcement agencies, and child victim services (n=648). The survey found that 94 percent of respondents were not serving LGBTQ survivors of IPV.¹⁸ For example, in 2011, more than 60 percent of LGBTQ IPV survivors who sought assistance at a shelter were turned away.¹⁹

Similar barriers exist in seeking support from law enforcement and the justice system.⁴ LGBTQ individuals are hesitant to seek law enforcement assistance and this hesitation is likely due to fear

of discrimination or harassment.⁴ Furthermore, state laws may not specifically grant protections to LGBTQ survivors. For example, state statutes on protection orders that do not include LGBTQ survivors are often decided on a case-by-case basis and are at the discretion of a judge.⁴

LEGISLATION

Violence Against Women Reauthorization Act of 2013

The Violence Against Women Act (VAWA) reauthorization of 2013 attempted to address the lack of services for LGBTQ survivors by including a non-discrimination clause. This clause provided that no person in the United States shall, based on actual or perceived race, color, religion, national origin, sex, gender identity, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity funded in whole or in part with funds made available under VAWA and any other program or activity funded in whole or in part with funds appropriated by the Office on Violence Against Women.²⁰ While there has not been an evaluation on the impact of this clause, it is worth noting that VAWA is up for reauthorization in 2018 and there are concerns this provision may be removed.

CONCLUSION

The lifetime prevalence of IPV in the LGBTQ community is estimated to be comparable to or higher than that among heterosexual couples. Much of the work that has been done to address the public health problem of IPV has focused on heterosexual women. There is limited information available on the aspects of IPV that are unique to same-sex relationships and the effects on LGBTQ survivors' mental and physical health. Research is also lacking on the best practices for identifying LGBTQ survivors of IPV. It is unclear if existing screening tools are relevant to LGBTQ survivors. In addition to effective screening tools, research is needed to determine the interventions that are effective in reducing the harms of IPV in the LGBTQ population. Furthermore, community resources to support LGBTQ survivors of IPV are limited. While the 2013 reauthorization of VAWA specifically provided for non-discrimination against sexual and gender minorities, the implementation and enforcement of this provision is unclear.

Despite the limited research available on this topic, physicians should be alert to the possibility of IPV among their LGBTQ patients and should familiarize themselves with resources available in their communities for LGBTQ survivors of IPV.

RECOMMENDATIONS

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 D-515.980, "Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals" be amended by addition and deletion to read as follows:

Our AMA will: (1) ~~study recent domestic violence data and the unique issues faced by the LGBTQ population; and~~ (2) promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ ~~victims~~ survivors of domestic violence, (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of intimate partner violence, and (3) advocate for federal funding to support programs and services for survivors of intimate partner violence that do not discriminate against underserved

1 communities, including on the basis of sexual orientation and gender identity. (Modify Current
2 HOD policy)
3

- 4 2. Our AMA encourages research on intimate partner violence in the LGBTQ community to
5 include studies on the prevalence, the accuracy of screening tools, effectiveness of early
6 detection and interventions, as well as the benefits and harms of screening. (New HOD Policy)
7

- 8 3. That Policy H-160.991, "Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer
9 Populations," be reaffirmed.
10

11 Our AMA will collaborate with our partner organizations to educate physicians regarding: (i)
12 the need for sexual and gender minority individuals to undergo regular cancer and sexually
13 transmitted infection screenings based on anatomy due to their comparable or elevated risk for
14 these conditions; and (ii) the need for comprehensive screening for sexually transmitted
15 diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk
16 for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or
17 gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience
18 intimate partner violence, and how sexual and gender minorities present with intimate partner
19 violence differs from their cisgender, heterosexual peers and may have unique complicating
20 factors. (Reaffirm HOD Policy)

Fiscal Note: Less than \$1,000

REFERENCES

1. Centers for Disease Control and Prevention. Intimate Partner Violence: Definitions. Available at: <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html>. Accessed August 10, 2018.
2. Walters, ML, Chen J, & Breiding, MJ. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Findings on Victimization by Sexual Orientation. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
3. Badenes-Ribera L, Bonilla-Campos A, Frias-Navarro D, Pons-Salvador G, Monderde IB. Intimate Partner Violence in Self-Identified Lesbians: A Systematic Review of Its Prevalence and Correlates. *Trauma Violence Abuse* 2016;17:284-297.
4. Calton JM, Cattaneo LB, Gebhard KT. Barriers to Help Seeking for Lesbian, Gay, Bisexual, Transgender, and Queer Survivors of Intimate Partner Violence. *Trauma Violence Abuse* 2016;17:585-600.
5. Edwards KM, Wylaska KM, Neal AM. Intimate Partner Violence Among Sexual Minority Populations: A Critical Review of the Literature and Agenda for Future Research. *Psych of Violence* 2015; 5(2): 112-121.
6. Brown TNT, Herman JL. Intimate Partner Violence and Sexual Abuse Among LGBT People: a Review of Existing Research. 2015. The Williams Institute. Available at <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Intimate-Partner-Violence-and-Sexual-Abuse-among-LGBT-People.pdf>. Accessed August 10, 2018.
7. Langenderfer-Magruder L, Whitfield DL, Walls NE, Kattari SK, Ramos D. Experiences of Intimate Partner Violence and Subsequent Police Reporting Among Lesbian, Gay, Bisexual, Transgender, and Queer Adults in Colorado: Comparing Rates of Cisgender and Transgender Victimization. *J Interpers Violence* 2016;31:855-871.
8. Woulfe JM, Goodman LA. Identity Abuse as a Tactic of Violence in LGBTQ Communities: Initial Validation of the Identity Abuse Measure. *J Interpers Violence* 2018;886260518760018.
9. Todahl JL, Linville D, Bustin A, Wheeler J, Gau J. Sexual assault support services and community systems: understanding critical issues and needs in the LGBTQ community. *Violence Against Women* 2009;15:952-976.
10. Houston E, McKirnan DJ. Intimate partner abuse among gay and bisexual men: risk correlates and health outcomes. *J Urban Health* 2007;84:681-690.
11. Reuter TR, Newcomb ME, Whitton SW, Mustanski B. Intimate Partner Violence Victimization in LGBT Young Adults: Demographic Differences and Associations with Health Behaviors. *Psychol Violence* 2017;7:101-109.
12. Ard KL, Makadon HJ. Addressing intimate partner violence in lesbian, gay, bisexual, and transgender patients. *J Gen Intern Med* 2011;26:930-933.
13. Leonardelli AT. Do Existing Screening Tools Accurately Reflect Experiences of LGBTQ-Identified Victims of Intimate Partner Violence? Oshkosh Scholar, pgs. 37-53.
14. U.S.Preventive Services Task Force. Final Recommendation Statement - Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: Screening. 2013.
15. U.S.Preventive Services Task Force. Draft Recommendation Statement - Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening. 2018.
16. Futures without Violence. FUTURES LGBTQ Intimate Partner Violence Materials. Available at: <https://www.futureswithoutviolence.org/health/lgbtq-ipv/>. Accessed August 10, 2018.
17. Smith, S.G., Chen, J., Basile, K.C., Gilbert, L.K., Merrick, M.T., Patel, N., Walling, M., & Jain, A. (2017). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

18. National Center for Victims of Crime and NCVAP. Why It Matters: Rethinking Victim Assistance for LGBTQ Victims of Hate Violence and Intimate Partner Violence. 2010.
19. National Coalition of Anti-Violence Programs. Lesbian, gay, bisexual, transgender, queer, and HIV-affected intimate partner violence. 2011.
20. PL 113-4. Violence Against Women Reauthorization Act of 2013.

REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-18)
FDA Expedited Review Programs and Processes
(Resolution 201-I-17)
(Reference Committee K)

EXECUTIVE SUMMARY

Objective. To examine expedited FDA drug approval programs or processes in place in the United States, including so-called fast track, accelerated approval, designated breakthrough therapies, and “priority review” for drugs and biologics, and whether the operation of such programs needs to be re-examined or modified.

Methods. English-language reports were selected from a PubMed and Google Scholar search from 1992 to August 2018, using the MeSh terms “*biomarkers,” “*surrogate end points,” “drug approval/*methods/*statistical outcomes/*legislation & jurisprudence, *validation,” “United States Food and Drug Administration,” product surveillance/*postmarketing” and “government regulation,” combined with the text terms “clinical trials,” “treatment outcome,” “accelerated approval,” “breakthrough therapy,” “priority review,” and “fast track.” Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of the U.S. Food and Drug Administration (FDA).

Results. Different programs have been put in place over the last 25 years by the FDA and Congress to expedite the review of promising new therapies and to approve drugs for initial marketing based on lower evidentiary standards, including the use of surrogate markers. The use of surrogate endpoints has assumed increasing importance as approximately 40% of pivotal clinical trials for drug approvals or new indications rely on them. More than 60% of fast track approvals are now characterized as specialty drugs. Priority review processes have been successful in reducing the average application review time. One overarching theme is the strength of evidence relied on by the FDA to support marketing of new drugs. While various analyses have been conducted over different time frames examining the impact of expedited review programs on drug safety and efficacy, the most comprehensive review found that, for the most part, the use of surrogate endpoints has been successful, and the majority of sponsors have approached the conduct of confirmatory studies in a timely manner, although some failures do exist.

Conclusion. Over the years, the FDA has implemented various approaches to expedite the review and approval of new drug and biologic applications, as well as new indications for existing products. Accelerated approval, fast track, prior review, and breakthrough therapy designations have been developed, but these expedited programs differ and should not be lumped together from a scientific, public health, or policy point of view. Key variables include the requirement for post-approval studies for drugs marketed under accelerated approval, whether a surrogate endpoint that has not been validated is used to support approval, and the need to confirm clinical benefit and the risk-benefit profile for drugs approved based on limited evidence, regardless of their review designation. While it is important for the agency to retain regulatory flexibility, and many positive aspects of expedited programs are apparent, some changes should be made to improve implementation, establish the value of surrogate endpoints, and provide more transparency for clinicians and their patients.

REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-I-18

Subject: FDA Expedited Review Programs and Processes
(Resolution 201-I-17)

Presented by: Robyn F. Chatman, MD, MPH, Chair

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

INTRODUCTION

Resolution 201-I-17, “Improving FDA Expedited Approval Pathways,” introduced by the Resident and Fellow Section and referred by the House of Delegates asked:

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

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

This report examines expedited FDA drug approval processes in place in the United States, including so-called fast track, accelerated approval, designated breakthrough therapies, and “priority review” for drugs and biologics. Such programs are “intended to facilitate and expedite development and review of new drugs to address unmet medical needs in the treatment of serious or life-threatening conditions” (especially when no satisfactory alternative therapies exist), and “be available to patients as soon as it can be concluded that the therapies’ benefits justify the risks.”¹⁻³ Accordingly, under the current regulatory structure for approval of new chemical entities or new indications (efficacy supplements), the specific drug development program, including eligibility for expedited programs, is determined by the seriousness and prevalence of the disease, availability of existing treatments, and evidence that the drug can offer significant improvement compared with available therapies.

Two specific topics, one referred to in the resolution (specialty drugs) and the other which also impacts the FDA’s review of new drug applications (user fees) are not specifically evaluated in this report. The FDA does not define “specialty drugs” nor is it a term found in regulations or statute. The term specialty drug is generally used for complex, high-cost medications; they are often derived from a living source, characterizing them as biologics. Historically, they have been used to treat serious, chronic conditions such as rare diseases, cancer, rheumatoid arthritis, and multiple sclerosis. In recent years, specialty drugs have targeted more common conditions such as high cholesterol, asthma and hepatitis C, significantly increasing the potential pool of patients that

receive them. Specialty drugs are not stocked at most pharmacies, are often injectable medications, and may have unique storage or shipment requirements, such as refrigeration. These medications usually require additional patient education and support beyond traditional dispensing and counseling activities to maintain adherence and ensure patient safety. The growth in specialty drugs has been exponential. In the past four years nearly 100 new specialty drugs were launched, and in the same time there were 80 supplemental approvals establishing new indications for existing products.⁴ Based on the number and high degree of success in getting such drugs approved, special attention to these types of drugs, with respect to drug development, is not warranted. Concerns also have been expressed that the high cost of many specialty drugs is not justified when compared with their clinical benefits. Cost is a variable that is not under the purview of the FDA.

The Prescription Drug User Fee Act (PDUFA), first enacted in 1992, established the current framework by which pharmaceutical manufacturers help fund the FDA by submitting a fee along with their application. Monies derived from so-called “user fees” have been used to expand FDA staffing dedicated to the review of new drug (NDA) and biological license applications (BLA) and efficacy supplements (sNDA); the latter are submitted when sponsors seek approval to add a new indication to prescription drug labeling. A comparable user fee process also is now in place for abbreviated new drug applications (ANDA) that govern generic drug approval. Because user fees support FDA drug reviews in general, and are not an expedited program or process *per se*, the impact of PDUFA review times on drug safety and patient benefits is not further evaluated in this report.

METHODS

English-language reports were selected from a PubMed and Google Scholar search from 1992 to August 2018, using the MeSh terms “*biomarkers,” “*surrogate end points,” “drug approval/*methods/*statistical outcomes/*legislation & jurisprudence, *validation,” “United States Food and Drug Administration,” product surveillance/*postmarketing” and “government regulation,” combined with the text terms “clinical trials,” “treatment outcome,” “accelerated approval,” “breakthrough therapy,” “priority review,” and “fast track.” Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet site of the US Food and Drug Administration (FDA).

CURRENT AMA POLICY

AMA Policy H-100.992, “FDA,” supports the concept that an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or postmarket incident reports *as provided by statute*. The statute regarding evidentiary standards for drug approval was modified in 1997 permitting FDA to approve a drug product “upon determination that the product has an effect on a clinical endpoint or on a surrogate endpoint that is reasonably likely to predict clinical benefit.” The evidence should be evaluated by the agency in consultation with its Advisory Committees and expert extramural advisory bodies, and any risk-benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.

Policy D-100.978, “FDA Drug Safety Policies,” directs the AMA to monitor and respond, as appropriate, to implementation of the drug safety provisions of the FDA Amendments Act of 2007 (FDAAA; P.L. 110-85). This directive was related primarily to the fact that FDA authorities around Risk Evaluation and Mitigation Strategies were strengthened by the 2007 law.

DESCRIPTION OF EXPEDITED DRUG AND BIOLOGIC APPROVAL PROCESSES

Regular approval was the only FDA approval pathway until 1992. Largely in response to the HIV/AIDS epidemic in the mid-late 1980s, the FDA institutionalized approaches by which certain drugs, including antiretroviral products at the time, could be initially approved based on less rigorous data, including the use of surrogate endpoints.

Accelerated Approval

Conceptualized in the 1980s, initially implemented in 1992 and further refined in 2012, the accelerated approval pathway for drugs and biologics is described in 21CFR parts 314 (subpart H) and 602 (subpart E) and contained in Section 506(c) of the Food Drug and Cosmetic (FD&C) Act.⁵⁻⁷ It has been primarily used in settings where the course of the disease is long and an extended period would be required to measure the intended clinical benefit (e.g., decreased mortality from HIV infection, increased overall survival from cancer). Qualifying criteria are a drug that treats a serious condition, generally provides a meaningful advantage over available therapies and demonstrates an effect on a “surrogate endpoint that is reasonably likely to predict clinical benefit or on a clinical endpoint that can be measured earlier than irreversible morbidity or mortality.” Furthermore, the surrogate endpoint is *reasonably likely* to predict an effect on “some other clinical benefit (i.e., an intermediate clinical endpoint), considering the severity, rarity, or prevalence of the condition and the availability or lack of alternative treatments.” The accelerated approval designation requires post-approval testing to verify efficacy and confirm the anticipated risk-benefit profile. From 2000 to 2103, 37 new drugs were granted accelerated approval, or about 10% of new molecular entities (NMEs).⁸

A drug marketed under accelerated approval can be subject to expedited withdrawal if the surrogate endpoint(s) turns out to be faulty. The FDA maintains a list of drugs that have been withdrawn due to safety concerns or lack of efficacy.⁹ Many of these products predate 1992. Since 1992 about 25 drugs have been withdrawn from the market, most of which had gone through regular approval. A limited number of drugs marketed under accelerated approval have had their approval for specific indications withdrawn (see below).

Surrogate Endpoints. A surrogate is “a laboratory measurement or physical sign that is used in therapeutic trials as a substitute for a clinically meaningful endpoint that is a direct measure of how a patient feels, functions, or survives and is expected to predict the effect of the therapy.”¹⁰ Such measures are not intrinsically beneficial to patients, but are relied on to predict the benefits of treatment in the absence of data on patient-relevant final outcomes based on a “reasonably likely” standard. The use of surrogate endpoints allows for clinical trials with reduced sample size and shorter duration, thereby reducing expense and speeding patient access to new therapies. For most drugs marketed under accelerated approval, requiring the endpoint to be overall survival is not practical and may not be ethical.¹¹

Approval of a drug based on a surrogate endpoint introduces uncertainty about the drug’s true clinical benefit and this degree of uncertainty must be considered acceptable in order for the new drug or indication to be approved. Different scenarios exist in which a treatment may significantly affect a surrogate marker, but not the clinically significant endpoint. The strength of evidence for validating a surrogate marker is based on: (1) the biological plausibility of the relationship between the surrogate marker and patient outcomes; (2) epidemiologic evidence on the predictive value of the surrogate for the clinical outcome of interest; and (3) clinical trial level data confirming that the response of the surrogate marker to treatment corresponds to the effects of the treatment on the clinical outcome.¹² Optimally, the strength of the surrogate-survival correlation would already be

established; however, many surrogate endpoints used during the drug approval process are not validated at the time. To validate all surrogate endpoints ahead of time would require several trials to be conducted on a specific research question, essentially defeating the purpose of the accelerated approval pathway.

The Use of Surrogate Endpoints for Drug Approval. Surrogate endpoints have assumed increasing importance as approximately 40% of pivotal trials constituting the basis for approval of NMEs and/or new indications for existing drugs are based on surrogate endpoints, with a high percentage of these being for oncology drugs.^{12,13}

Several studies have been published examining the use of surrogate endpoints and accelerated approval of oncology drugs over the past 25 years.¹⁴⁻¹⁶ Two snapshots covered the periods from 1994-2004 and 2004-2011, with a few others covering different time periods.^{16,17} A comprehensive review of oncology drugs approved as NMEs and for new indications via accelerated approval (n=93) was recently published covering the period from the inception of the program (1992) through May 2017 and is the focus of the following discussion.¹⁶

Twenty-eight percent of accelerated approvals were supported by randomized controlled trials (RCTs), with single arm trials accounting for the remainder; the median patient population for determining efficacy was 143. Seven RCTs used time to progression as the end point and four used disease-free survival; the remainder of both RCTs and single arm trials (87%) used response rate (i.e., tumor burden) as the endpoint. Approximately 55% of the approvals have fulfilled their post-marketing requirements and verified benefit in a median 3.4 years after approval, based on measurement of progression-free survival or time to progression (i.e., disease control) (39%), overall survival (29%), response rate (26%) or disease-free recurrence or progression (6%). Most of the success stories had ongoing confirmatory trials planned and underway at the time of accelerated approval. Forty percent of accelerated approvals are still in the process of completing confirmatory trials and verifying clinical benefit; FDA approval was subsequently withdrawn for five new indications. Most of the unfulfilled commitments represent recent approvals (median time on the market = 18 months), although some outliers exist; eight of such products have been on the market for more than 5 years, mostly in rare patient populations. While one criticism of the accelerated approval pathway is the smaller sample size, review of documentation supporting accelerated approval indicates that the safety database is usually larger, about double the efficacy database.¹⁶ The safety database includes patients “treated with the drug regardless of age, condition, or volunteer status.”¹⁶ If the accelerated approval is for a new indication of an already-approved drug then more expansive safety information and postmarketing data are already available. Only one cancer drug approved under accelerated approval has been withdrawn from the market because of both efficacy and safety issues (gemtuzumab ozogamicin), and this drug was later reapproved for a narrower population.¹⁹

Several trial-level analyses have “quantified the association between surrogate endpoints and overall survival, with one study finding that nearly 50% of meta-analyses reported correlation between surrogate outcomes and overall survival exceeding 0.7. On average surrogate endpoints are positively correlated with survival.”²⁰

Fast Track Designation

The current fast track designation is defined in section 506(b) of the FD&C, as amended by the 1997 Food and Drug Modernization Act (section 112) and 2012 Food and Drug Administration Safety and Innovation Act (FDASIA) (section 109). This designation was designed to facilitate the development, and expedite the review of drugs to *treat serious conditions and fill an unmet*

1 *medical need*. Some critics maintain that the term “unmet medical need” has been overused and is
 2 too imprecise.²¹ This pathway also is available for drugs that have been designated as a qualified
 3 infectious disease product. Fast track allows for approval based on preliminary evidence such as
 4 Phase 2 clinical studies (rarely Phase 1). A request for fast track designation can be filed with the
 5 investigational new drug application (IND) or after, but ideally before the pre-NDA or BLA
 6 meeting; the timeline for an FDA decision is within 60 calendar days of receipt of the request.

7
 8 Actions to expedite development and review include more frequent interactions with the review
 9 team to discuss, in part, study design, the extent of safety data required to support approval, dose-
 10 response concerns and use of biomarkers, and a “rolling review” where parts of the application can
 11 be acted on when they are ready, in sequence. Drugs with fast track designation also could be
 12 eligible for *priority review* (see below) if such a request is supported by sufficient data when the
 13 NDA, BLA, or efficacy supplement submission is submitted. Fast track designations can be
 14 rescinded if qualifying criteria are not met.

15
 16 From 2000 to 2013, the FDA approved 82 drugs under the fast track designation, or approximately
 17 22% of the NME’s approved during the same time period.⁸ More than 60% of the fast track
 18 approvals were characterized as specialty drugs by the authors of this study.

19 20 *Breakthrough Therapy*

21
 22 Described in Section 506(a) of the FD&C Act, the breakthrough therapy designation was created
 23 by the 2012 FDASIA to expedite the development and review of drugs which may demonstrate
 24 substantial improvement over available therapy. Qualifying criteria are that a drug is intended to
 25 treat a *serious condition* and *preliminary clinical evidence* indicates that the drug may demonstrate
 26 “substantial improvement on a clinically significant endpoint over available therapies.” The
 27 timeline for FDA response is the same as fast track and priority designations. In contrast to the fast
 28 track designation which could include theoretical or non-clinical data, a breakthrough designation
 29 requires clinical evidence which is sufficient to demonstrate substantial improvement in safety or
 30 effectiveness over available therapies, but additional evidence is still required for final approval.
 31 Determining if the “substantial improvement” criterion is met is a matter of judgement, and the
 32 evidence that is relied on for approval of drugs with this designation is heterogenous.²² This
 33 designation triggers intensive guidance on the drug development program beginning as early as
 34 Phase 1, FDA commitment involving senior FDA managers, a rolling review of the application and
 35 eligibility for *priority review* designation.

36 37 *Priority Review*

38
 39 This process was established by the 1992 PDUFA to improve the efficiency of NDA reviews for
 40 NMEs. A priority review designation can be assigned to applications for drugs “that treat *serious*
 41 *conditions* and provide *significant improvements* in the safety or effectiveness of the treatment,
 42 diagnosis, or prevention of serious conditions *compared to available therapies*.”³ A priority review
 43 designation is assigned at the time of the NDA, BLA or efficacy supplement filing. Priority review
 44 can be granted to applications for drugs with fast track or breakthrough therapy designation, or to
 45 applications submitted for review under accelerated approval. That decision is based on the
 46 information and data available at the time the application is submitted.”¹

47
 48 The timeline for FDA response is the same as fast track designations with a shorter timeframe for
 49 reviewing the application versus standard review cycles (6 months compared with the 10-month
 50 target for the latter). From FY 2007 through FY 2016, the (average) median time to application
 51 approval was 11.4 months for standard review compared with 7.9 months for priority review.²³

CLINICAL TRIAL EVIDENCE AND EXPEDITED REVIEW PROGRAMS

A Perspective on New Drug Safety-Related Issues

One study conducted on postmarket safety outcomes for all NMEs (n=278) approved from 2002-2014 demonstrated that safety updates to the product labeling were the rule rather than the exception.²⁴ At least one safety update was added to 195 (70.1%) of the products, most commonly between the 2nd and 8th year after marketing. Safety information was added earlier after marketing for drugs approved with a fast-track designation or under an accelerated approval using a surrogate end point; safety issues also were more likely to arise for drugs with a fast track designation.

Evidentiary Standards

Another perspective on drugs approved via expedited reviews is to examine the strength of evidence accompanying market approvals, which clearly has important implications for patients, physicians, and payers. Concern has been expressed about the potential lack of systematic monitoring for confirmation of effectiveness for drugs that have been approved based on limited evidence, compared with standard approvals.²⁵

One recent review of cancer drugs approved from 2006-2016 found that when RCTs were lacking, approved indications were more likely to be based on accelerated approval, receive a breakthrough designation or have a companion diagnostic test. Indications not supported by RCTs had higher odds of post approval safety changes, but not major modifications in indications and dosage, warnings and precautions, boxed warnings, or contraindication sections of the labeling.²⁶

Analysis of all drugs approved by the FDA from 2005-2012 revealed that most indications were supported by at least 1 RCT, although more than one-third of indications were approved based on a single pivotal efficacy trial. Substantial variation existed in terms of the comparators and end points, trial duration, number of participants, and completion rates.¹² Surrogate endpoints served as the primary outcome for 91 of 206 (44%) of the approved indications.

From 2005-2014, 295 supplemental NDAs for new indications were submitted. Thirty percent of these were supported by efficacy trials with an active comparator and 32% used a clinical endpoint. Among those expanding the patient population (almost all pediatric), only 11% used an active comparator, with 22% using a clinical endpoint.²⁷

DISCUSSION

Over the years, the FDA has implemented various approaches to expedite the review and approval of new drug and biologic applications, as well as new indications for existing products. Under the current regulatory structure, the specific drug development program, including eligibility for expedited programs, is determined by the seriousness and prevalence (or rarity) of the disease, availability of existing treatments, and evidence that the new drug can offer significant improvement compared with available therapies and/or otherwise address an unmet medical need. Accelerated approval, fast track, priority review, and breakthrough therapy designations have been developed to consider and address these variables. These expedited programs differ and should not be lumped together from a scientific, public health, or policy point of view. Key variables include the requirement for post-approval studies for drugs marketed under accelerated approval, whether a surrogate endpoint that has not been validated is used to support approval, and the need to confirm clinical benefit and the risk-benefit profile for drugs approved based on limited evidence, regardless of their review designation.

1 It has been argued that the process of approving medications based on more limited evidence,
2 including fewer patients and patient years of exposure, makes the process of reducing healthcare
3 disparities costlier.²⁸ Earlier drug approval reduces the power of studies to detect difference in risk
4 and benefit in relevant subgroups and could direct the burden of medical uncertainty toward groups
5 of people who are often disadvantaged. It may be advisable for the FDA to encourage that
6 confirmatory trials enable appropriate sub-group analyses that were not possible during initial,
7 lower-powered studies. Accelerating drug approval shifts the burdens of uncertainty away from
8 clinical trial participants (who have undergone informed consent) to others who are exposed to the
9 treatment under different conditions, socializing the costs of uncertainty while pharmaceutical
10 companies profit from new drug development. The relevant question is “whether earlier access to
11 drugs, driven by changes in regulatory policy or growing reliance on surrogate endpoints, benefits
12 or harms patients.”²⁹

13
14 Confirmatory studies are needed for drugs approved based on limited evidence to avoid exposing
15 patients to potentially unsafe or ineffective therapies. Even the use of uncertain surrogate endpoints
16 is not problematic if confirmatory studies reliably demonstrate meaningful clinical endpoints. A
17 report from the Government Accountability Office, in referring to the FDA’s activities in this area,
18 concluded that “the agency needs to clarify the conditions under which it would use its authority to
19 expedite the withdrawal of drugs granted accelerate approval,” when confirmatory studies are not
20 conducted in a timely manner or fail to confirm predicted benefits.³⁰

21
22 Over the past 15 years, most accelerated approvals were for oncologic drugs, and that experience is
23 instructive. The accelerated approval of bevacizumab for breast cancer has been held up as a prime
24 example of harm, because it was approved based on the endpoint of progression-free survival, but
25 eventually this drug was shown to not increase overall survival.¹⁹ However, “clear and convincing
26 evidence” has emerged from phase 2 (and some phase 1) trials leading to marketing approval of
27 new chemical entities within 2-3 years accounting for “advances in treatment for molecular subsets
28 of non-small cell lung cancer, melanoma, chronic leukemia, breast cancer, and acute myeloid
29 leukemia,” among others.¹⁹

30
31 Although critics have condemned a lack of “improved survival” as the optimal endpoint for clinical
32 trials, there has been a “steady improvement in U.S. cancer mortality and survival over the past 2
33 decades.”¹⁹ in part because of new treatments, but also better screening and early detection.
34 Nevertheless, more than half of oncologic drugs marketed under accelerated approvals relied on a
35 surrogate endpoint that was chosen in the absence of any formal analysis of the strength of the
36 surrogate-survival connection.³¹ This observation reinforces the need for timely determination of
37 the predicted clinical benefit and confirmation of the risk-benefit profile.

38
39 Comprehensive evaluation of oncologic drugs marketed under accelerated approval confirms that
40 satisfactory progress has been made on confirmatory trials. By balancing risk, accounting for
41 uncertainty, and operating under a paradigm of regulatory flexibility, existing FDA expedited
42 pathways can ensure early access to, and appropriate use of new drugs and biologics, including
43 specialty drugs. The Institute of Medicine recommended that the FDA should “implement a benefit
44 and risk assessment and management plan that would summarize the FDA’s evaluation of drug’s
45 risk-benefit profile in a single document and that would be continuously updated” during the life-
46 cycle of the drug on the market.^{32,33} While it is important for the agency to retain regulatory
47 flexibility, and mostly positive aspects of expedited programs are apparent, some changes should
48 be made to improve implementation, establish the value of surrogate endpoints, and provide more
49 transparency for physicians and their patients on the level of evidence used for marketing approval.

RECOMMENDATION

The Council on Science and Public Health recommends that Policy H-100.992 be amended by addition and deletion to read as follows in lieu of Res-201-I-17, and the remainder of the report be filed:

(1) Our AMA ~~reaffirms its~~ supports ~~for~~ the principles that:

(a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or postmarket incident reports as provided by statute;

(b) ~~the~~is evidence for drug approval should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies;

(c) expedited programs for drug approval serve the public interest as long as sponsors for drugs that are approved based on surrogate endpoints or limited evidence conduct confirmatory trials in a timely fashion to establish the expected clinical benefit and predicted risk-benefit profile;

(d) confirmatory trials for drugs approved under expedited programs should be planned and underway at the time of expedited approval;

(e) the FDA should pursue having in place a systematic process to ensure that sponsors adhere to their obligations for confirmatory trials, and Congress should establish a firmer threshold to trigger expedited withdrawal when sponsors fail to fulfill their postmarketing study obligations;

~~(d-f)~~ any risk-benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications; and,

(g) FDA should consider a simple system to assign a grade for each approval of prescription drugs occurring via expedited programs in order to signal, and provide in a transparent manner, the quality of clinical trial evidence used to establish safety and effectiveness, and whether confirmatory trials are required for labeled indications.

(2) The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.

(3) It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.

Fiscal Note: Less than \$500

REFERENCES

1. U.S. Food and Drug Administration. Guidance for Industry. Expedited Programs for Serious Conditions — Drugs and Biologics.
2. 21 CFR 312.300(b)(1).
3. Manual of Policies and Procedures. Center for Drug Evaluation and Research. Office of New Drugs. Review Designation Policy: Priority (P) and Standard (S) [h](#).
4. What's special about specialty? <https://cvshealth.com/thought-leadership/whats-special-about-specialty>.
5. Code of Federal Regulations. §314.510. https://www.ecfr.gov/cgi-bin/text-idx?SID=7e3afa31ba9326a86c1c08ca7cb22f4c&mc=true&node=se21.5.314_1510&rgn=div8. December 11, 1992. Accessed August 13, 2018.
6. Code of Federal Regulations. §601.41. https://www.ecfr.gov/cgi-bin/text-idx?SID=c03234aa22abbed0380923a4cc6ab001&mc=true&node=se21.7.601_141&rgn=div8. December 11, 1992. Accessed August 13, 2018.
7. Food and Drug Administration Safety and Innovation Act, 21 USC §301. <https://www.gpo.gov/fdsys/pkg/PLAW-112publ144/pdf/PLAW-112publ144.pdf>. July 9, 2012. Accessed August 13, 2018.
8. Kesselheim AS, Yongtian TT, Darrow JJ, Avorn J. Existing FDA pathways have potential to ensure early access to, and appropriate use of, specialty drugs. *Health Affairs*. 2014;10:1770-78.
9. 21 CFR. §216.24. Drug products withdrawn or removed from the market for reasons of safety or effectiveness.
10. Temple R. Are surrogate markers adequate to assess cardiovascular disease drugs. *JAMA*. 1999. 282;790-95.
11. Califf RM. Balancing the need for access with the imperative for empirical evidence of benefit and risk. *JAMA*. 2017;318(7):614-616.
12. Ciani O, Buyse M, Drummond M, et al. Time to review the role of surrogate end points in health policy: state of the art and the way forward. *Value Health*. 2017;20:487-95.
13. Downing NS, Aminawung JA, Shah ND ,et al. Clinical trial evidence supporting FDA approval of novel therapeutic agents,2005–2012. *JAMA*. 2014;311:368–77.
14. Dagher R, Johnson J, Williams G, Keegan P, Pazdur R. Accelerated approval of oncology products: a decade of experience. *J Natl Cancer Inst*. 2004;96(20):1500-1509.
15. Johnson JR, Ning YM, Farrell A, Justice R, Keegan P, Pazdur R. Accelerated approval of oncology products: the Food and Drug Administration experience. *J Natl Cancer Inst*. 2011;103(8):636-644.
16. Beaver JA, Howie LJ, Pelosof L, et al. A 25-year experience of US Food and Drug Administration Accelerated Approvals of Malignant Hematology and Oncology Drugs and Biologics. *JAMA Oncology*. 2018;84956.
17. Shea M, Roberts SA, Walrath JC, Allen JD, Sigal EV. Use of multiple endpoints and approval paths depicts a decade of FDA oncology drug approvals. *Clin Cancer Res*. 2013;19:3722-31.

18. Richey E, Lyons A, Nebeker JR, et al. Accelerated approval of cancer drugs: Improved access to therapeutic breakthroughs or early release of unsafe and ineffective drugs. *J Clin Oncology*. 2009;27:4398-4405
19. Chabner BA. Regarding "Oncology drug approvals: Evaluating endpoints and evidence in an era of breakthrough therapies. *Oncologist*. 2017 Jul;22(7): 757–758.
20. Prasad V, Kim C, Burotto M, Vandross A. The strength of association between surrogate endpoints and survival in oncology: a systematic review of trial level meta-analyses. *JAMA Intern Med*. 2015;175:1389-98.
21. Kemp R, Prasad V. Surrogate endpoints in oncology: when are they acceptable for regulatory and clinical decisions, and are they currently overused. *BMC Medicine*. 2017. 15:134.
22. U.S Food and Drug Administration. FY 2017. Performance Report to Congress for the Prescription Drug User Fee Act.
23. Herink MC, Irwin AN, Zumach GM. FDA breakthrough therapy designation: Evaluating the quality of the evidence behind the drug approvals. *Pharmacotherapy*. 2018; Jul 24. doi: 10.1002/phar.2167.
24. Pinnow E, Amr S, Bentzen SM et al. Postmarket safety outcomes for new molecular entity (NME) drugs approved by the food and drug administration between 2002 and 2014. *Clin Pharmacol Ther*. 2018;104:390-400.
25. Hatswell AJ, Baio G, Berlin JA, Irs A, Freemantle N. Regulatory approval of pharmaceuticals without a randomized controlled study: analysis of EMA and FDA approvals 1999-2014. *BMJ Open*. 2016;6:e011666. doi:10.1136/bmjopen-2016-011666.
26. Shephelovich D, Tibau A, Goldvaser H, et al. Postmarketing modifications of drug labels for cancer drugs approved by the US Food and Drug Administration between 2006 and 2016 with and without supporting randomized controlled trials. *J Clin Oncology*. 2018;36:1798-1804.
27. Wang B, Kesselheim AS. Characteristics of efficacy evidence supporting approval of supplemental indications for prescription drugs in United States, 2005-14: systematic review. *Brit Med J*. 2015;351:h4679. doi: 10.1136/bmj.h4679.
28. London AJ. Accelerated drug approval and health inequality. *JAMA Int Med*. 2016;176:883-4.
29. Jena AB, Zhang Jie, Lakdawalia DN. The trade-off between speed and safety in drug approvals. *JAMA Oncology*. 2017;3:1465-66.
30. Government Accountability Office. GAO-09-866. New Drug Approval. FDA Needs to Enhance Its Oversight of Drugs Approved on the Basis of Surrogate Endpoints. September 2009. <https://www.gao.gov/new.items/d09866.pdf>. Accessed August 25, 2018.
31. Kim C, Prasad V. Strength of validation for surrogate end points used in the U.S. Food and Drug Administration's approval of oncology drugs. *Mayo Clin Proc*. 2016 May 10. pii: S0025-6196(16)00125-7. doi: 10.1016/j.mayocp.2016.02.012.
32. Institute of Medicine. Ethical and Scientific Issues in Studying the Safety of Approved Drugs. Washington, DC. National Academy Press. 2012.
33. Psaty BM, Medlin EM, Breckenrisdige A. A lifecycle approach to the evaluation of FDA approval methods and regulatory actions: opportunities, provided by a new IOM report. *JAMA*. 2012;307:2491-92.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 901
(I-18)

Introduced by: Medical Student Section

Subject: Support for Preregistration in Biomedical Research

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, Current AMA policy calls for physicians to “report the results of research accurately, including subsequent negative findings”, particularly when “the findings do not support the research hypothesis”;¹ and

Whereas, There are hurdles to the publication of negative research findings because of publication bias wherein journals are less likely to accept manuscripts reporting negative findings;² and

Whereas, The AMA supports the reproducibility of research findings by advocating that scientific research “employ study designs that will yield scientifically valid and significant data”;³ and

Whereas, There is a systemic lack of reproducibility among published biomedical research studies⁴, as highlighted by a recent report finding that nearly 70% of researchers were unable to reproduce another scientist’s results;^{4,5} and

Whereas, Preregistration of a research study is the act of committing to clearly defined research questions and analytical plans prior to the observation of the research outcomes, usually achieved by posting an analysis plan to an independent registry;⁶ and

Whereas, Establishing hypotheses prior to observation of outcomes has been associated with a four-fold reduction in rates of reporting false positive findings, suggesting that preregistration can increase replicability of research;⁷ and

Whereas, The proportion of large clinical trials reporting negative findings increased from 43% to 92% after preregistration of clinical trials became mandatory in the United States, showing that “preregistration is correlated with outcomes that suggest reduced publication or reporting biases;”⁸ therefore be it

¹ AMA Code of Medical Ethics Opinion E-7.2.1 Principles for Disseminating Research Results

² Nosek BA, Ebersole CR, DeHaven AC, Mellor DT. The Preregistration Revolution. *Proceedings of the National Academy of Sciences*. 2018;115(11):2600-2606. doi:[10.1073/pnas.1708274114](https://doi.org/10.1073/pnas.1708274114); Franco A, Malhotra N, Simonovits G. Publication Bias in the Social Sciences: Unlocking the File Drawer. *Science*. 2014;345(6203):1502-1505.

³ AMA Code of Medical Ethics Opinion E-7.1.3 Study Design and Sampling

⁴ Ioannidis JPA. Why Most Published Research Findings Are False. *PLoS Medicine*. 2005;2(8):e124.

doi:[10.1371/journal.pmed.0020124](https://doi.org/10.1371/journal.pmed.0020124); Begley CG, Ellis LM. Drug Development: Raise Standards for Preclinical Cancer Research. *Nature*. 2012;483(7391):531.

⁵ Baker M. 1,500 Scientists Lift the Lid on Reproducibility. *Nature*. 2016;533(7604):452-454.

⁶ Nosek BA, et al. The Preregistration Revolution.

⁷ Swaen GGMH, Teggeler O, van Amelsvoort LGPM. False Positive Outcomes and Design Characteristics in Occupational Cancer Epidemiological Studies. *International Journal of Epidemiology*. 2001;30(5):948-954.

⁸ Kaplan RM, Irvin VL. Likelihood of Null Effects of Large NHLBI Cancer Trials Has Increased Over Time. *PLoS One*. 2015;10(8):e0132382; Nosek BA, et al. The Preregistration Revolution.

- 1 RESOLVED, That our American Medical Association support preregistration in order to mitigate
2 publication bias and improve the reproducibility of biomedical research. (New HOD Policy)

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

Date Received: 09/21/18

RELEVANT AMA POLICY

E-7.1.3 Study Design & Sampling

To be ethically justifiable, biomedical and health research that involves human subjects must uphold fundamental principles of respect for persons, beneficence, and justice. These principles apply not only to the conduct of research, but equally to the selection of research topics and study design.

Well-designed, ethically sound research aligns with the goals of medicine, addresses questions relevant to the population among whom the study will be carried out, balances the potential for benefit against the potential for harm, employs study designs that will yield scientifically valid and significant data, and generates useful knowledge. For example, research to develop biological or chemical weapons is antithetical to the goals of the medical profession, whereas research to develop defenses against such weapons can be ethically justifiable.

Physicians who engage in biomedical or health research with human participants thus have an ethical obligation to ensure that any study with which they are involved:

- (a) Is consistent with the goals and fundamental values of the medical profession.
- (b) Addresses research question(s) that will contribute meaningfully to medical knowledge and practice.
- (c) Is scientifically well designed to yield valid data to answer the research question(s), including using appropriate population and sampling controls, clear and appropriate inclusion/exclusion criteria, a statistically sound plan for data collection and analysis, appropriate controls, and when applicable, criteria for discontinuing the study (stopping rules).
- (d) Minimizes risks to participants, including risks associated with recruitment and data collection activities, without compromising scientific integrity.
- (e) Provides mechanisms to safeguard confidentiality.
- (f) Does not disproportionately recruit participants from historically disadvantaged populations or populations whose ability to provide fully voluntary consent is compromised. Participants who otherwise meet inclusion/exclusion criteria should be recruited without regard to race, ethnicity, gender, or economic status.
- (g) Recruits participants who lack the capacity to give informed consent only when the study stands to benefit that class of participants and participants with capacity would not yield valid results. In this event, assent should be sought from the participant and consent should be obtained from the prospective participants legally authorized representative, in keeping with ethics guidance.
- (h) Has been reviewed and approved by appropriate oversight bodies.

[AMA Principles of Medical Ethics: I,II,III,V,VII](#)

Issued: 2016

E-7.2.1 Principles for Disseminating Research Results

Physicians have an ethical responsibility to learn from and contribute to the total store of scientific knowledge. When they engage in biomedical or health research, physicians have obligations as scientists, which include disseminating research findings. Prompt presentation to scientific peers and publication of research findings are foundational to good medical care and promote enhanced patient care, early evaluation of clinical innovations, and rapid dissemination of improved techniques.

To fulfill their ethical responsibilities with respect to sharing research findings for the ultimate benefit of patients, physicians should:

- (a) Advocate for timely and transparent dissemination of research data and findings. Physicians should not intentionally withhold information for reasons of personal gain.
- (b) Report the results of research accurately, including subsequent negative findings. This is particularly important where the findings do not support the research hypothesis.
- (c) Maintain a commitment to peer review.
- (d) Disclose sponsorship and conflicts of interest relating to the research, in keeping with ethics guidance.
- (e) Be responsible in their release of research results to the media, ensuring that any information the researcher provides is prompt and accurate and that informed consent to the release of information has

been obtained from research participants (or participants legally authorized representative when the participant lacks decision-making capacity) prior to releasing any identifiable information. In rare circumstances, the potential for misuse of research results could affect the decision about when and whether to disseminate research findings. Physician-researchers should assess foreseeable ramifications of their research in an effort to balance the promise of benefit against potential harms from corrupt application. Only under rare circumstances should findings be withheld, and then only to the extent required to reasonably protect against misuse.

[AMA Principles of Medical Ethics: I,II,III,V,VII](#)

Issued: 2016

Food Additives H-150.998

Our AMA supports the passage of legislation that would amend the Food Additive Act to require evidence based upon scientifically reproducible studies of the association of food additives with an increased incidence of cancer in animals or humans at dosage levels related to the amounts calculated as normal daily consumption for humans before removal of an additive from the market.

Citation: (Sub. Res. 4, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00;

Modified: BOT Rep. 6, A-10)

Increasing Minority Participation in Clinical Research H-460.911

1. Our AMA advocates that:

- a. The Food and Drug Administration (FDA) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
- b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and
- c. Resources be provided to community level agencies that work with those minorities who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities in clinical trials:

- a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs;
- b. Increased outreach to female physicians to encourage recruitment of female patients in clinical trials;
- c. Continued minority physician education on clinical trials, subject recruitment, subject safety, and possible expense reimbursements;
- d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and
- e. Fiscal support for minority recruitment efforts and increasing trial accessibility through transportation, child care, reimbursements, and location.

3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.

BOT Rep. 4, A-08 Reaffirmed: CSAPH Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 902
(I-18)

Introduced by: Medical Student Section

Subject: Increasing Patient Access to Sexual Assault Nurse Examiners

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, One in 6 women and 1 in 33 men have experienced an attempted or completed rape in their lifetime, and there were 323,450 reports of rape or sexual assault in the United States in 2016;^{1,2} and

Whereas, Hospital emergency departments (EDs) typically serve as the primary point of care for survivors of sexual assault, accounting for approximately 65,000–90,000 emergency department visits per year;³ and

Whereas, The medical forensic examination (MFE) consists of a full head-to-toe physical examination focused on documenting a patient's physical injuries and procuring DNA evidence to assist in the prosecution of a case;⁴ and

Whereas, Performing a MFE has been shown to increase prosecution rates, and patients who have chosen to undergo the MFE may do so to gain closure and emotional healing from the traumatic event;⁵ and

Whereas, While the MFE can be completed by a variety of healthcare providers including emergency medicine (EM) physicians, nurses/nurse practitioners, and physician assistants, EM physicians are the primary examiner performing these exams despite recommendations that encourage the involvement of other providers;^{4,6} and

Whereas, The MFE takes on average two hours to perform, must be completed within 72 hours of the assault, and a chain of custody must be maintained where the examiner cannot leave the evidence unattended until it is sealed for storage or handed to an authorized law enforcement agent;^{4,7} and

Whereas, EM physicians typically see 2.48 patients per hour, which makes it difficult to effectively complete the MFE and maintain custody of the evidence alongside their clinical responsibilities;^{4,8} and

¹ RAINN, "Victims of Sexual Violence: Statistics | RAINN," 2018, <https://www.rainn.org/statistics/victims-sexual-violence>.

² Rachel Morgan and Grace Kena, "Criminal Victimization, 2016," 2017, <https://www.bjs.gov/content/pub/pdf/cv16.pdf>.

³ Ashlesha Patel et al., "Assessing the Extent of Provision of Comprehensive Medical Care Management for Female Sexual Assault Patients in US Hospital Emergency Departments," *International Journal of Gynecology & Obstetrics* 123, no. 1 (October 2013): 24–28, <https://doi.org/10.1016/j.ijgo.2013.04.014>.

⁴ Kristin Littel, "A National Protocol for Sexual Assault Medical Forensic Examinations - Adults/Adolescents Second Edition," 2013, <https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf>.

⁵ Janice Du Mont, Deborah White, and Margaret J. McGregor, "Investigating the Medical Forensic Examination from the Perspectives of Sexually Assaulted Women," *Social Science & Medicine* 68, no. 4 (February 1, 2009): 774–80, <https://doi.org/10.1016/J.SOCSCIMED.2008.11.010>.

⁶ Margaret K Sande et al., "Sexual Assault Training in Emergency Medicine Residencies: A Survey of Program Directors," *The Western Journal of Emergency Medicine* 14, no. 5 (September 2013): 461–66, <https://doi.org/10.5811/westjem.2013.2.12201>.

⁷ "What Is a Rape Kit? | RAINN," accessed April 11, 2018, <https://www.rainn.org/articles/rape-kit>.

⁸ Joseph Harrington, "Patient-Per-Hour Staffing Ratios Over the Last 5 Years of EDBA Surveys," ACEP Now, 2016, http://www.acepnow.com/article/emergency-department-benchmarking-alliance-releases-2014-data-on-staffing-physician-productivity/acep_0116_pg13b/.

Whereas, There is currently no national consensus on EM resident education for sexual assault examinations, leading to EM physicians who are undertrained to complete the MFE;⁹ and

Whereas, Sexual assault nurse examiners (SANE) are health care personnel specially trained to perform the MFE and their involvement is associated with higher rates of survivors' psychological recovery and offender prosecution due to better collection of forensic data;^{10,11} and

Whereas, Although there are now over 600 SANE programs nationwide, many EDs lack access to SANE personnel, especially in rural or smaller communities;^{12,13} and

Whereas, The United States Government Accountability Office released a study highlighting "weak stakeholder support for examiners" as one of the main reasons for poor availability of SANE personnel;¹⁴ and

Whereas, The American College of Emergency Physicians, the International Association of Forensic Nurses, and the Department of Justice all recommend that the MFE be performed by specially trained medical personnel such as a SANE, and the Police Foundation in Texas found that there is "reluctance by nurses, hospital administrators and criminal justice officials to [have] non-SANEs conduct medical forensic exams";^{14,15} and

Whereas, Expanding the SANE program nationwide may decrease the burden on ED physicians and provide better care to sexual assault survivors;^{4,15} therefore be it

RESOLVED, That our American Medical Association advocate for increased patient access to sexual assault nurse examiners in the emergency department. (New HOD Policy)

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

Date Received: 09/21/18

RELEVANT AMA POLICY

Sexual Assault Survivors H-80.999

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.

2. Our AMA advocates for the legal protection of sexual assault survivors rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (A) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (B) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (C) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (D) be informed of these rights and the policies governing the sexual assault evidence kit; and (E) access to emergency contraception information and treatment for pregnancy prevention.

⁹ Margaret K Sande et al., "Sexual Assault Training in Emergency Medicine Residencies: A Survey of Program Directors.," *The Western Journal of Emergency Medicine* 14, no. 5 (September 2013): 461–66, <https://doi.org/10.5811/westjem.2013.2.12201>.

¹⁰ Megan R. Greeson and Rebecca Campbell, "Coordinated Community Efforts to Respond to Sexual Assault," *Journal of Interpersonal Violence* 30, no. 14 (September 13, 2015): 2470–87, <https://doi.org/10.1177/0886260514553119>.

¹¹ Rebecca Campbell, Debra Patterson, and Lauren F. Lichty, "The Effectiveness of Sexual Assault Nurse Examiner (SANE) Programs," *Trauma, Violence, & Abuse* 6, no. 4 (October 29, 2005): 313–29, <https://doi.org/10.1177/1524838005280328>.

¹² "International Association of Forensic Nurses," 2018, accessed March 28, 2018, <http://www.forensicnurses.org/>

¹³ Liv Osby, "SC Has a Shortage of Nurses for Rape Victims," *The State*, 2017, <http://www.thestate.com/news/local/article162841233.html>.

¹⁴ Katherine M. Iritani, "Information on Training, Funding, and the Availability of Forensic Examiners," *United States Government Accountability Office* 16, no. 334 (2016), <https://www.gao.gov/assets/680/675879.pdf>.

¹⁵ Robert C Davis et al., "IMPACT OF SB1191 ON ACCESSIBILITY OF SEXUAL ASSAULT FORENSIC EXAMS IN TEXAS," 2017, http://www.policefoundation.org/wp-content/uploads/2017/02/PF_Impact-of-SB1191-on-Accessibility-of-Sexual-Assault-Forensic-Exams-in-Texas_2.7.17.pdf.

3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.

Citation: Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: Res. 202, I-17

Sexual Assault Survivor Services H-80.998

Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.

Citation: Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17

Access to Emergency Contraception H-75.985

It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.

Citation: (CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14)

HIV, Sexual Assault, and Violence H-20.900

Our AMA believes that HIV testing should be offered to all victims of sexual assault, that these victims should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained.

Citation: (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 903
(I-18)

Introduced by: Medical Student Section

Subject: Regulating Front-of-Package Labels on Food Products

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, Many front-of-package (FOP) labels on food products feature nutrient claims that suggest or imply that a food has certain nutritional properties related to its content of energy, proteins, fats, carbohydrates, dietary fiber, vitamins, and/or minerals; and

Whereas, FOP labels attract attention, thereby causing consumers to spend less time reading the nutrition facts on the back and side panel of food products^{1,2}; and

Whereas, Research demonstrates that consumers will exhibit a preference for a product with a FOP nutrient claim regardless of its qualitative value³; and

Whereas, Studies show that children perceive food products with nutrient claims on their FOP label as healthier⁴; and

Whereas, Studies of responses to nutrition-related claims in food advertising have found that consumers over-generalize a product's healthfulness based on narrower claims^{5,6,7,8}; and

Whereas, Many front-of-package labels (e.g. "Whole Grain" on sugary cereals and "Good Source of Vitamins and Minerals" on toaster pastries) are placed on products that contain high amounts of added sugar,⁹ meaning they do not comply with the 2015-2020 U.S. Dietary Guidelines' recommendation that food products contain no more than 10% added sugars by calorie value; and

¹ Bix, L., Sundar, R. P., Bello, N. M., Peltier, C., Weatherspoon, L. J., & Becker, M. W. (2015). To See or Not to See: Do Front of Pack Nutrition Labels Affect Attention to Overall Nutrition Information? *Plos One*, 10(10). doi:10.1371/journal.pone.0139732

² Becker, M. W., Sundar, R. P., Bello, N., Alzahabi, R., Weatherspoon, L., & Bix, L. (2016). Assessing attentional prioritization of front-of-pack nutrition labels using change detection. *Applied Ergonomics*, 54, 90-99. doi:10.1016/j.apergo.2015.11.014

³ Hamlin, R. P., McNeill, L. S., & Moore, V. (2014). The impact of front-of-pack nutrition labels on consumer product evaluation and choice: An experimental study. *Public Health Nutrition*, 18(12), 2126-2134. doi:10.1017/s1368980014002997

⁴ Nutrition Claims Influence Health Perceptions and Taste Preferences in Fourth- and Fifth-Grade Children. (2012, September 23). Retrieved April 5, 2018, from <https://www.sciencedirect.com/science/article/pii/S1499404612003958>

⁵ Andrews, J. C., R. G. Netemeyer, and S. Burton. 1998. Consumer generalization of nutrient content claims in advertising. *Journal of Marketing* 62:62-75.

⁶ Kozup, J., E. Creyer, and S. Burton. 2003. Making healthful food choices: The influence of health claims and nutrition information on consumers' evaluations of packaged food products and restaurant menu items. *Journal of Marketing* 67:19-34.

⁷ Gorton, D., C. N. Mhurchu, D. Bramley, and R. Dixon. 2010. Interpretation of two nutrition content claims: A New Zealand survey. *Australian and New Zealand Journal of Public Health* 34:57-62.

⁸ Labiner-Wolfe, J., C. T. J. Lin, and L. Verrill. 2010. Effect of low-carbohydrate claims on consumer perceptions about food products' healthfulness and helpfulness for weight management. *Journal of Nutrition Education and Behavior* 42:315-320.

⁹ Ollberding, N. J., Wolf, R. L., & Contento, I. (2010). Food label use and its relation to dietary intake among US adults. *Journal of the American Dietetic Association*, 110(8), 1233-1237.

Whereas, Evidence shows that individuals who consume diets high in refined carbohydrates are at a greater risk of becoming obese¹⁰, developing diabetes¹¹, and dying from a cardiovascular event¹²; and

Whereas, The Food and Drug Administration (FDA) regulates front-of-package claims by enforcing qualifying criteria that food products must meet for use of each individual nutrient claim¹³; and

Whereas, The FDA has no requirement that food products labeled with nutrient claims that can be generalized to imply healthfulness adhere to specific macronutrient limits; and

Whereas, Studies show that negative cues in the form of warning labels are demonstrated to have a greater impact on consumer food choices than positive health claims^{14,15,16}; and

Whereas, Standardized warning labels have been mandated in Chile on food products high in sugar, salt, fat, and calories since 2016¹⁷; and

Whereas, To avoid having to add warning labels to their products, food companies in Chile have reformulated over 1,500 food products to be lower in sugar, salt, fat, and calories¹⁸; and

Whereas, Chilean consumers purchase more of the foods without warning labels than they did before implementation of the warning labels^{19,20}; and

Whereas, Our AMA and AMA-MSS have established support for consumer-level interventions and education about the effects of excessive dietary sugars (H-150.960, H-150.974, H-150.935, H-150.945, D-150.975, D-150.987); and

Whereas, Our AMA and AMA-MSS have established support for the use of warning labels and plain packaging on sugar-sweetened beverages (H-150.927); therefore be it

¹⁰ Cantoral, A., Téllez-Rojo, M. M., Ettinger, A. S., Hu, H., Hernández-Ávila, M., & Peterson, K. (2015). Early introduction and cumulative consumption of sugar-sweetened beverages during the pre-school period and risk of obesity at 8-14 years of age. *Pediatric Obesity*, 11(1), 68-74. doi:10.1111/ijpo.12023

¹¹ Gross, L. S., Li, L., Ford, E. S., & Liu, S. (2004). Increased consumption of refined carbohydrates and the epidemic of type 2 diabetes in the United States: An ecologic assessment. *The American Journal of Clinical Nutrition*, 79(5), 774-779. doi:10.1093/ajcn/79.5.774

¹² Yang, Q., Zhang, Z., Gregg, E. W., Flanders, W. D., Merritt, R., & Hu, F. B. (2014). Added Sugar Intake and Cardiovascular Diseases Mortality Among US Adults. *JAMA Internal Medicine*, 174(4), 516. doi:10.1001/jamainternmed.2013.13563

¹³ Subpart D—Specific Requirements for Nutrient Content Claims, 58 FR 2413 (1993); 58 FR 17343 (1993), as amended at 58 FR § 44033 (1993); 62 FR § 40598 (1997); 63 FR § 26718 (1998); 63 FR § 40024 (1998); 67 FR § 9585 (2002); 69 FR § 16481 (2004).

¹⁴ Arrúa, A., Machín, L., Curutchet, M. R., Martínez, J., Antúnez, L., Alcaire, F., . . . Ares, G. (2017). Warnings as a directive front-of-pack nutrition labelling scheme: Comparison with the Guideline Daily Amount and traffic-light systems. *Public Health Nutrition*, 20(13), 2308-2317. doi:10.1017/s1368980017000866

¹⁵ Bollard, T., Maubach, N., Walker, N., & Mhurchu, C. N. (2016). Effects of plain packaging, warning labels, and taxes on young people's predicted sugar-sweetened beverage preferences: An experimental study. *International Journal of Behavioral Nutrition and Physical Activity*, 13(1). doi:10.1186/s12966-016-0421-7

¹⁶ Arrúa, A., Curutchet, M. R., Rey, N., Barreto, P., Golovchenko, N., Sellanes, A., . . . Ares, G. (2017). Impact of front-of-pack nutrition information and label design on childrens choice of two snack foods: Comparison of warnings and the traffic-light system. *Appetite*, 116, 139-146. doi:10.1016/j.appet.2017.04.012

¹⁷ Carreño, I. (2015). Chiles Black STOP Sign for Foods High in Fat, Salt or Sugar. *European Journal of Risk Regulation*, 6(04), 622-628. doi:10.1017/s1867299x0000516x

¹⁸ Ares, G., Aschemann-Witzel, J., Curutchet, M. R., Antúnez, L., Machín, L., Vidal, L., & Giménez, A. (2018). Product reformulation in the context of nutritional warning labels: Exploration of consumer preferences towards food concepts in three food categories. *Food Research International*, 107, 669-674. doi:10.1016/j.foodres.2018.03.021

¹⁹ Ares, G., Aschemann-Witzel, J., Curutchet, M. R., Antúnez, L., Machín, L., Vidal, L., & Giménez, A. (2018). Product reformulation in the context of nutritional warning labels: Exploration of consumer preferences towards food concepts in three food categories. *Food Research International*, 107, 669-674. doi:10.1016/j.foodres.2018.03.021

²⁰ Arrúa, A., Curutchet, M. R., Rey, N., Barreto, P., Golovchenko, N., Sellanes, A., . . . Ares, G. (2017). Impact of front-of-pack nutrition information and label design on childrens choice of two snack foods: Comparison of warnings and the traffic-light system. *Appetite*, 116, 139-146. doi:10.1016/j.appet.2017.04.012

- 1 RESOLVED, That our American Medical Association support additional U.S. Food and Drug
- 2 Administration criteria that limit the amount of added sugar a food product can contain if it
- 3 carries any front-of-package label advertising nutritional or health benefits (New HOD Policy);
- 4 and be it further
- 5
- 6 RESOLVED, That our AMA support the use of front-of-package warning labels on foods that
- 7 contain excess added sugar. (New HOD Policy)

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

Date Received: 09/24/18

RELEVANT AMA POLICY

Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-Food and Other Chain Restaurants H-150.945

Our AMA:

1. supports federal, state, and local policies to require fast-food and other chain restaurants with 10 or more units (smaller, neighborhood restaurants could be exempt) to provide consumers with nutrition information on menus and menu boards;
2. recommends that nutrition information in fast-food and other chain restaurants include calorie, fat, saturated fat and trans fat, and sodium labeling on printed menus, and, at a minimum, calories on menu boards, since they have limited space, and that all nutrition information be conspicuous and easily legible;
3. urges federal, state, and local health agencies, health organizations, and physicians and other health professionals to educate people how to use the nutrition information provided in restaurants to make healthier food choices for themselves and their families; and
4. urges restaurants to improve the nutritional quality of their menu offerings--for example, by reducing caloric content; offering smaller portions; offering more fruits, vegetables, and whole-grain items; using less sodium; using cooking fats lower in saturated and trans fats; and using less added sugars/sweeteners.

Citation: (Res. 419, A-07; Reaffirmed in lieu of Res. 413, A-09, Res. 416, A-09 and Res. 418, A-09)

Encouraging Healthy Eating Behaviors in Children Through Corporate Responsibility H-150.935

Our AMA: 1) supports and encourages corporate social responsibility in the use of marketing incentives that promote healthy childhood behaviors, including the consumption of healthy food in accordance with federal guidelines and recommendations; and 2) encourages fast food restaurants to establish competitive pricing between less healthy and more healthy food choices in children's meals.

Citation: (Sub. Res. 402, A-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 435, A-12)

Support for Uniform, Evidence-Based Nutritional Rating System H-150.936

1. Our AMA supports the adoption and implementation of a uniform, nutritional food rating system in the US that meets, at a minimum, the following criteria: is evidence-based; has been developed without conflict of interest or food industry influence and with the primary goal being the advancement of public health; is capable of being comprehensive in scope, and potentially applicable to nearly all foods; allows for relative comparisons of many different foods; demonstrates the potential to positively influence consumers' purchasing habits; provides a rating scale that is simple, highly visible, and easy-to-understand and used by consumers at point of purchase; and is adaptable to aid in overall nutritional decision making.
 2. Our AMA will advocate to the federal government - including responding to the Food and Drug Administration call for comments on use of front-of-package nutrition labeling and on shelf tags in retail stores - and in other national forums for the adoption of a uniform, evidence-based nutrition rating system that meets the above-referenced criteria.
- Citation: (Res. 424, A-10)

Support for Nutrition Label Revision and FDA Review of Added Sugars D-150.974

1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period.
2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added

sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA).

3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.

Citation: (Res. 422, A-14)

Increasing Awareness of Nutrition Information and Ingredient Lists H-150.948

Our AMA supports federal legislation or rules requiring restaurants, retail food establishments, and vending machine operators that have menu items common to multiple locations, as well as all school and workplace cafeterias, especially those located in health care facilities, to have available for public viewing ingredient lists, nutritional information, and standard nutrition labels for all menu items.

Citation: (Sub. Res. 411, A-04; Reaffirmation A-07; Reaffirmed in lieu of Res. 413, A-09, Res. 416, A-09 and Res. 418, A-09; Modified: BOT Rep. 1, A-14)

Strategies to Reduce the Consumption of Beverages with Added Sweeteners H-150.927

Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption, and support evidence-based strategies to reduce the consumption of SSBs, including but not limited to, excise taxes on SSBs, removing options to purchase SSBs in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption, such as controlling portion sizes; limiting options to purchase or access SSBs in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and replacing SSBs with healthier beverage choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage choices for students.

Citation: CSAPH Rep. 03, A-17;

Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake H-150.929

Our AMA will:

(1) Call for a step-wise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade. Food manufacturers and restaurants should review their product lines and reduce sodium levels to the greatest extent possible (without increasing levels of other unhealthy ingredients). Gradual but steady reductions over several years may be the most effective way to minimize sodium levels.

(2) To assist in achieving the Healthy People 2010 goal for sodium consumption, will work with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, and other interested partners to educate consumers about the benefits of long-term, moderate reductions in sodium intake.

(3) Recommend that the FDA consider all options to promote reductions in the sodium content of processed foods.

Citation: CSAPH Rep. 01, A-16

Obesity as a Major Health Concern H-440.902

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of patients with obesity; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat patients affected by obesity.

Citation: Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04; Reaffirmation A-10; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Modified: Res. 402, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 904
(I-18)

Introduced by: Medical Student Section

Subject: Support for Continued 9-1-1 Modernization and the National Implementation of Text-to-911 Service

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, The current 9-1-1 system is primarily built upon an infrastructure that does not uniformly support modern communications technologies including texting, geolocation, and images;^{1, 2} and

Whereas, Current 9-1-1 infrastructure has continuously been shown to be vulnerable to preventable outages and cyberattacks, which have already temporarily left thousands without access to emergency services;^{3, 4, 5} and

Whereas, The Federal Communications Commission (FCC) has already recommended that Congress increase federal incentives to boost state and local 9-1-1 modernization efforts;⁶ and

Whereas, Internet protocol (IP)- based communication technologies allow the transmission of data over the internet, allowing for increased information (such as text and geolocation) to be obtained by the receiver compared to old circuit-switch communication;⁷ and

Whereas, Congress has failed to nationally incorporate IP based technology into existing 9-1-1 infrastructure, which may lead to inaccurate caller location accuracy on calls over wireline in multiple situations;⁸ and

Whereas, 95% of Americans own at least one cellphone, 77% own at least one smartphone, and over 70% of all 9-1-1 calls are made from cellphones and other handheld devices;^{9, 10} and

Whereas, While the IP-based geolocation accuracy of handheld devices averages about 4.9 meters, current U.S. standards merely mandate that 67% of 9-1-1 calls are accurate within range of 50 meters, a standard that has not been updated since 2012;^{11, 12} and

¹ Federal Communications Commission. 2013. Pursuant to the Next Generation 911 Advancement Act of 2012 (Pub. L. No. 112-96 (2012)). Legal and Regulatory Framework for Next Generation 911 Services Report to Congress and Recommendations. Section 1.

² Next Generation 9-1-1 Advancement Act of 2011, 47 U.S.C §158. (2012)

³ Public Safety and Homeland Security Bureau. Federal Communications Commission. 2013. Impact of the June 2012 Derecho on Communications Networks and Services: Report and Recommendations. Sections 1, 7.4, & 8.

⁴ Public Safety and Homeland Security Bureau. Federal Communications Commission. 2014. April 2014 Multistate 911 Outage: Cause and Impact. Sections 1, & 4.2.

⁵ Simpson, D. (2016, February 17). Creating a Culture of Cybersecurity in America's 911 Call Centers. Retrieved March 28, 2018, from <https://www.fcc.gov/news-events/blog/2016/01/28/creating-culture-cybersecurity-america's-911-call-centers>

⁶ Federal Communications Commission. 2013. Pursuant to the Next Generation 911 Advancement Act of 2012 (Pub. L. No. 112-96 (2012)). Legal and Regulatory Framework for Next Generation 911 Services Report to Congress and Recommendations. Section 4.1.1.2

⁷ Federal Communications Commission. 2013. Pursuant to the Next Generation 911 Advancement Act of 2012 (Pub. L. No. 112-96 (2012)). Legal and Regulatory Framework for Next Generation 911 Services Report to Congress and Recommendations. Section 3.1.2.

⁸ Federal Communications Commission. 2017. Inquiry Concerning 911 Access, Routing, and Location in Enterprise Communications Systems: Notice of Inquiry – PS Docket No. 17-239. Sections 1 & 2.

⁹ Mobile Fact Sheet. Pew Research Center. (2018, February 05). Retrieved March 28, 2018, from <http://www.pewinternet.org/fact-sheet/mobile/>

¹⁰ Federal Communications Commission. 2015. Consumer Guide: 911 Wireless Services. Available at <https://transition.fcc.gov/cgb/consumerfacts/wireless911srvc.pdf>

¹¹ 911 service, 47 C.F.R. § 20.18(h) (2012).

¹² GPS Accuracy. (2017, December 5). Retrieved March 25, 2018, from <https://www.gps.gov/systems/gps/performance/accuracy/>

Whereas, Increased 9-1-1 response times, due to factors such as imprecise call tracking, can lead to increased morbidity in cardiac arrest;¹³ and

Whereas, The Americans with Disabilities Act of 1990 mandates that 9-1-1 services need only receive message-based communication from teletypewriters (TTYs), devices which are distinct and may be incompatible with modern mobile and smartphones;^{14, 15} and

Whereas, Approximately 50 million Americans have hearing disabilities, and 7.5 million Americans have difficulty vocalizing words;^{16, 17} and

Whereas, The FCC found a majority of those with hearing and speech disabilities have discarded their TTYs in favor of mobile plans with SMS services, leaving millions with these disabilities at risk of not being able to effectively communicate with 9-1-1 operators;¹⁵ and

Whereas, Nationally, 9-1-1 call centers are not mandated to accept SMS messages (text-to-911), meaning that a citizen's locale may dictate the amount of emergency services they have access to;¹⁸ and

Whereas, The National Association of the Deaf (NAD) and the Hearing Loss Association of America (HLAA) both acknowledge that the existing 9-1-1 infrastructure limits the ability of those with deafness or hearing loss to contact emergency services;^{19, 20} and

Whereas, The NAD and HLAA both support continued modernization of 9-1-1 services, including the continued implementation of text-to-911;^{19, 20} and

Whereas, Our AMA has adopted policy encouraging guidelines that protect against the reallocation of 9-1-1 funding to unrelated programs (H-440.822), but does not currently encourage the continued modernization of 9-1-1 services; therefore be it

RESOLVED, That our American Medical Association support the funding of federal grant programs for the modernization of the 9-1-1 infrastructure, including incorporation of text to 911 technology. (New HOD Policy)

Fiscal note: Minimal - less than \$1,000.

Date Received: 09/24/18

RELEVANT AMA POLICY

Accountability of 911 Emergency Services Funding H-440.822

Our AMA encourages federal guidelines and state legislation that protects against reallocation of 911 funding to unrelated services.

Citation: Res. 220, A-17

¹³ Emergency medical services response to cardiac arrest. (2015). In R. Graham, M. McCoy & A. Schultz (Eds.), Strategies to improve cardiac arrest survival: A time to act. (pp. 190-192). National Academies Press, 500 Fifth Street, NW, Keck 360, Washington, DC 20001: National Academies Press. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK321505/>

¹⁴ Americans With Disabilities Act of 1990, Pub. L. No. 101-336, § IV (2012)

¹⁵ Federal Communications Commission. 2013. Pursuant to the Next Generation 911 Advancement Act of 2012 (Pub. L. No. 112-96 (2012)). Legal and Regulatory Framework for Next Generation 911 Services Report to Congress and Recommendations. Section 4.1.6.1.

¹⁶ Statistics on Voice, Speech, and Language. National Institute on Deafness and Other Communication Disorders. (2016, July 11). Retrieved March 28, 2018, from <https://www.nidcd.nih.gov/health/statistics/statistics-voice-speech-and-language>

¹⁷ Blackwell DL, Lucas JW, Clarke TC. Summary health statistics for U.S. adults: National Health Interview Survey, 2012. National Center for Health Statistics. Vital Health Stat 10(260). 2014.

¹⁸ Federal Communications Commission. 2017. Consumer Guide: Text-to-911: What You Need to Know. Available at <https://transition.fcc.gov/cgb/consumerfacts/text-to-911-consumer-guide.pdf>

¹⁹ National Association of the Deaf. (2018). Next generation 9-1-1 emergency services. Retrieved from <https://www.nad.org/resources/emergency-preparedness/next-generation-9-1-1-emergency-services/>

²⁰ Hearing Loss Association of America. (2018). 911. Retrieved from <http://www.hearingloss.org/content/911>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 905
(I-18)

Introduced by: Medical Student Section

Subject: Support Offering HIV Post Exposure Prophylaxis to All Survivors of Sexual Assault

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, 19.3% of women and 1.7% of men in the United States report being raped during their lifetime, and 1.8 per 1000 children have been sexually abused;¹ and

Whereas, The Centers for Disease Control and Prevention (CDC) estimates the risk of contracting HIV from a known HIV-positive person through consensual vaginal intercourse at 0.1%–0.2% and anal intercourse at 0.5%–3%, and this risk may increase during sexual assault due to injuries sustained by the individual;^{2,3} and

Whereas, Post-Exposure Prophylaxis (PEP) is antiretroviral medication (ART) taken within 72 hours of HIV exposure to prevent infection, and is extremely effective at preventing seroconversion after HIV exposure;^{4,5,6,7,8,9,10} and

Whereas, Current CDC guidelines indicate that persons with nonoccupational exposure to HIV should be offered PEP within 72 hours even if the HIV status of the exposor is unknown;^{11,12} and

¹ Arlene C. Seña et al., "Sexual Assault and Sexually Transmitted Infections in Adults, Adolescents, and Children," *Clinical Infectious Diseases* 61, no. suppl 8 (December 15, 2015): S856–64, doi:10.1093/cid/civ786.

² Jessica E Draughon, "Sexual Assault Injuries and Increased Risk of HIV Transmission.," *Advanced Emergency Nursing Journal* 34, no. 1 (2012): 82–87, doi:10.1097/TME.0b013e3182439e1a.

³ Jennifer F Klot et al., "Greentree White Paper: Sexual Violence, Genitoanal Injury, and HIV: Priorities for Research, Policy, and Practice.," *AIDS Research and Human Retroviruses* 28, no. 11 (November 2012): 1379–88, doi:10.1089/AID.2012.0273.

⁴ Réjean Thomas et al., "Adherence to Post-Exposure Prophylaxis (PEP) and Incidence of HIV Seroconversion in a Major North American Cohort," ed. Cristian Apetrei, *PLOS ONE* 10, no. 11 (November 11, 2015): e0142534, doi:10.1371/journal.pone.0142534.

⁵ M. E. Roland et al., "Seroconversion Following Nonoccupational Postexposure Prophylaxis against HIV," *Clinical Infectious Diseases* 41, no. 10 (November 15, 2005): 1507–13, doi:10.1086/497268.

⁶ Sarah J. McDougal et al., "Non-Occupational Post-Exposure Prophylaxis for HIV: 10-Year Retrospective Analysis in Seattle, Washington," ed. Roger Le Grand, *PLoS ONE* 9, no. 8 (August 20, 2014): e105030, doi:10.1371/journal.pone.0105030.

⁷ F Tissot et al., "Nonoccupational HIV Post-Exposure Prophylaxis: A 10-Year Retrospective Analysis," *HIV Medicine* 11, no. 9 (October 1, 2010): 584–92, doi:10.1111/j.1468-1293.2010.00826.x.

⁸ Trine Gulholm et al., "Non-Occupational HIV Post-Exposure Prophylaxis at a Sydney Metropolitan Sexual Health Clinic," *Sexual Health* 10, no. 5 (November 2013): 438, doi:10.1071/SH13018.

⁹ Cadi Irvine et al., "Efficacy of HIV Postexposure Prophylaxis: Systematic Review and Meta-Analysis of Nonhuman Primate Studies," *Clinical Infectious Diseases* 60, no. suppl_3 (June 1, 2015): S165–69, doi:10.1093/cid/civ069.

¹⁰ U.S. Department of Health & Human Services, "Post-Exposure Prophylaxis," 2015, <https://www.hiv.gov/hiv-basics/hiv-prevention/using-hiv-medication-to-reduce-risk/post-exposure-prophylaxis>.

¹¹ Kenneth L. Dominguez et al., "Updated Guidelines for Antiretroviral Postexposure Prophylaxis after Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV—United States, 2016," 2016, <https://stacks.cdc.gov/view/cdc/38856>.

¹² AIDS Institute Clinical Guidelines, "PEP for Victims of Sexual Assault Guideline" (Baltimore, MD: HIV Clinical Resource, 2016), <https://www.hivguidelines.org/pep-for-hiv-prevention/after-sexual-assault/>.

Whereas, Hospital emergency departments (EDs) typically serve as the primary point of care for survivors of sexual assault, accounting for approximately 65,000–90,000 emergency department visits per year;¹³ and

Whereas, Only 14.5% of assault survivors were offered PEP, and only 8.5% of uninsured assault survivors were offered PEP in a 2009 survey of 117 Los Angeles Emergency Departments;¹⁴ and

Whereas, A 2018 meta-analysis found that the nationally pooled mean of individuals who were sexually assaulted and offered PEP at studied emergency departments was 55.9%;¹⁵ and

Whereas, There is no national consensus on emergency medicine residents' education about sexual assault examinations, which results in suboptimal care for the survivors of sexual assaults;^{13,16,17,18,19} and

Whereas, A qualitative study in 2016 of sexual assault patients found that physicians neglecting to offer PEP is a major barrier to patient access, disproportionately affecting those who are homeless or uninsured;^{11,20} and

Whereas, The same study indicated that the physicians neglected to offer PEP or they provided incorrect counseling due to a lack of knowledge about state or national PEP guidelines and a 2013 study found 20% of emergency physicians were not aware CDC PEP guidelines;^{20,21} and

Whereas, The cost of PEP is between \$600-\$1000, and persons prescribed PEP after sexual assault can be reimbursed for medications and clinical care costs through state Crime Victim's Compensation Programs funded by the U.S. Department of Justice;^{22,23,24} and

¹³ Ashlesha Patel et al., "Assessing the Extent of Provision of Comprehensive Medical Care Management for Female Sexual Assault Patients in US Hospital Emergency Departments," *International Journal of Gynecology & Obstetrics* 123, no. 1 (October 2013): 24–28, doi:10.1016/j.ijgo.2013.04.014.

¹⁴ Raphael J. Landovitz, Kory B. Combs, and Judith S. Currier, "Availability of HIV Postexposure Prophylaxis Services in Los Angeles County," *Clinical Infectious Diseases* 48, no. 11 (June 1, 2009): 1624–27, doi:10.1086/598976.

¹⁵ Meredith Scannell, Tiffany Kim, and Barbara J. Guthrie, "A Meta-Analysis of HIV Postexposure Prophylaxis Among Sexually Assaulted Patients in the United States," *Journal of the Association of Nurses in AIDS Care* 29, no. 1 (January 2018): 60–69, doi:10.1016/j.jana.2017.10.004.

¹⁶ Margaret K Sande et al., "Sexual Assault Training in Emergency Medicine Residencies: A Survey of Program Directors.," *The Western Journal of Emergency Medicine* 14, no. 5 (September 2013): 461–66, doi:10.5811/westjem.2013.2.12201.

¹⁷ Samantha Schilling et al., "Testing and Treatment After Adolescent Sexual Assault in Pediatric Emergency Departments.," *Pediatrics* 136, no. 6 (December 2015): e1495–503, doi:10.1542/peds.2015-2093.

¹⁸ Monika K Goyal et al., "Enhancing the Emergency Department Approach to Pediatric Sexual Assault Care: Implementation of a Pediatric Sexual Assault Response Team Program.," *Pediatric Emergency Care* 29, no. 9 (September 2013): 969–73, doi:10.1097/PEC.0b013e3182a21a0d.

¹⁹ R. C. Merchant et al., "Compliance in Rhode Island Emergency Departments With American Academy of Pediatrics Recommendations for Adolescent Sexual Assaults," *PEDIATRICS* 121, no. 6 (June 1, 2008): e1660–67, doi:10.1542/peds.2007-3100.

²⁰ Valentina Djelaj, Debra Patterson, and Christina M. Romero, "A Qualitative Exploration of Sexual Assault Patients' Barriers to Accessing and Completing HIV Prophylaxis," *Journal of Forensic Nursing* 13, no. 2 (2017): 45–51, doi:10.1097/JFN.0000000000000153.

²¹ Allan E Rodríguez et al., "HIV Medical Providers' Perceptions of the Use of Antiretroviral Therapy as Nonoccupational Postexposure Prophylaxis in 2 Major Metropolitan Areas.," *Journal of Acquired Immune Deficiency Syndromes (1999)* 64 Suppl 1, no. 0 1 (November 1, 2013): S68–79, doi:10.1097/QAI.0b013e3182a901a2.

²² Office for Victims of Crime, "U.S. Resource Map of Crime Victim Services & Information," *Office of Justice Programs*, 2016, <https://ojp.gov/ovc/map.html>.

²³ Michigan Department of Health & Human Services, "Crime Victim Services," *Crime Victim Services*, 2018, http://www.michigan.gov/mdhhs/0,5885,7-339-71548_54783_54853---,00.html.

²⁴ Office of Epidemiology & Prevention Services, "Post-Exposure Prophylaxis (PEP) FAQs," *West Virginia Department of Health & Human Resources*, 2018, [https://dhhr.wv.gov/oeps/std-hiv-hep/needlestick/Pages/Post-ExposureProphylaxis\(PEP\)FAQs.aspx](https://dhhr.wv.gov/oeps/std-hiv-hep/needlestick/Pages/Post-ExposureProphylaxis(PEP)FAQs.aspx).

Whereas, The estimated lifetime cost for HIV treatment was \$367,134 in 2009 and \$379,668 in 2010, and the estimated medical cost saved by preventing one HIV infection is \$229,800;^{25, 26} and

Whereas, Many living with HIV may find it challenging to perform daily tasks, participate in moderate physical activities, or have the energy to engage in an active social life;²⁷ therefore be it

RESOLVED, That our American Medical Association advocate for education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines (New HOD Policy); and be it further

RESOLVED, That our AMA support increased public education about the effective use of Post-Exposure Prophylaxis for HIV (New HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-20.900 by addition and deletion as follows:

H-20.900, "HIV, Sexual Assault, and Violence"

Our AMA believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all victims survivors of sexual assault, that these victims survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained. (Modify Current HOD Policy)

Fiscal note: Minimal - less than \$1,000.

Date Received: 09/21/18

RELEVANT AMA POLICY:

E-8.1 Routine Universal Screening for HIV

Physicians primary ethical obligation is to their individual patients. However, physicians also have a long-recognized responsibility to participate in activities to protect and promote the health of the public.

Routine universal screening of adult patients for HIV helps promote the welfare of individual patients, avoid injury to third parties, and protect public health.

Medical and social advances have enhanced the benefits of knowing ones HIV status and at the same time have minimized the need for specific written informed consent prior to HIV testing. Nonetheless, the ethical tenets of respect for autonomy and informed consent require that physicians continue to seek patients informed consent, including informed refusal of HIV testing.

To protect the welfare and interests of individual patients and fulfill their public health obligations in the context of HIV, physicians should:

- (a) Support routine, universal screening of adult patients for HIV with opt-out provisions.
- (b) Make efforts to persuade reluctant patients to be screened, including explaining potential benefits to the patient and to the patients close contacts.
- (c) Continue to uphold respect for autonomy by respecting a patients informed decision to opt out.
- (d) Test patients without prior consent only in limited cases in which the harms to individual autonomy are offset by significant benefits to known third parties, such as testing to protect occupationally exposed health care professionals or patients.
- (e) Work to ensure that patients who are identified as HIV positive receive appropriate follow-up care and counseling.
- (f) Attempt to persuade patients who are identified as HIV positive to cease endangering others.

²⁵ CDC Division of HIV/AIDS Prevention, "HIV Cost-Effectiveness," *HIV/AIDS*, 2017, <https://www.cdc.gov/hiv/programresources/guidance/costeffectiveness/index.html>.

²⁶ Bruce R Schackman et al., "The Lifetime Medical Cost Savings from Preventing HIV in the United States.," *Medical Care* 53, no. 4 (April 2015): 293–301, doi:10.1097/MLR.0000000000000308.

²⁷ K H Basavaraj, M A Navya, and R Rashmi, "Quality of Life in HIV/AIDS.," *Indian Journal of Sexually Transmitted Diseases* 31, no. 2 (July 2010): 75–80, doi:10.4103/0253-7184.74971.

(g) Be aware of and adhere to state and local guidelines regarding public health reporting and disclosure of HIV status when a patient who is identified as HIV positive poses significant risk of infecting an identifiable third party. The doctor may, if permitted, notify the endangered third party without revealing the identity of the source person.

(h) Safeguard the confidentiality of patient information to the greatest extent possible when required to report HIV status.

[AMA Principles of Medical Ethics: I, VI, VII](#)

Issued: 2016

Sexual Assault Survivor Services H-80.998

Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.

Citation: Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17

HIV, Sexual Assault, and Violence H-20.900

Our AMA believes that HIV testing should be offered to all victims of sexual assault, that these victims should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained.

Citation: (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

Access to Emergency Contraception H-75.985

It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.

Citation: (CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14)

HIV Postexposure Prophylaxis for Medical Students During Electives Abroad D-295.970

Our AMA: (1) recommends that US medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV prophylaxis; and (2) encourages medical schools to provide information to medical students regarding the potential health risks of completing a medical rotation abroad, and on the appropriate precautions to take to minimize such risks.

Citation: (Res. 303, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895

1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.

2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.

3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.

4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.

Citation: Res. 106, A-16; Modified: Res. 916, I-16; Appended: Res. 101, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 906
(I-18)

Introduced by: Medical Student Section

Subject: Increased Access to Identification Cards for the Homeless Population

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, More than 3.5 million Americans will experience homelessness at some point in a given year, and 77,486 of these individuals are chronically homeless;^{1,2} and

Whereas, The AMA supports public policy initiatives pertaining to access to care, and in particular supports improving health outcomes and decreasing health care costs for the homeless population (H-160.903, H-160.798, H-345.975, H-185.944); and

Whereas, Lack of identification serves as a major barrier for homeless individuals seeking medical care, in particular preventing them from enrolling in Medicaid, with 45.1% of the homeless without photo identification denied access to Medicaid or medical services;^{3,4,5} and

Whereas, Over 36% of the U.S. homeless population suffers from a severe mental illness or chronic substance abuse, and lack of identification among the homeless prevents them from accessing drug treatment and rehabilitation programs;^{6,7} and

Whereas, Forty-three states allow for pharmacists to require photograph identification from individuals prior to dispensing prescription drugs;⁸ and

Whereas, Unsheltered homeless individuals often have poorer health, less access to healthcare, and an increased risk of premature mortality compared to the sheltered homeless;⁹ and

¹ National Law Center on Homelessness & Poverty. (2004). *Photo Identification Barriers Faced by Homeless Persons: The Impact of September 11*. Washington, DC. <https://www.nlchp.org/documents/ID_Barriers>

² Department of Housing and Urban Development. (2017). *Sheltered Homeless Persons in Detroit (MI) 10/1/2016 - 9/30/2017*. Detroit: 2017 Annual Homeless Assessment Report.

<<https://static1.squarespace.com/static/5344557fe4b0323896c3c519/t/5a7c751608522985c2a3c780/1518105882011/2017+AHAR+All+Persons+Report+FINAL+from+HDX.pdf>>

³ Michigan Commission on Community Action and Economic Opportunity. (2016). *State Identification Cards*. Michigan Department of Health and Human Services.

<https://www.michigan.gov/documents/mdhhs/Commission_Report_State_Identification_Cards_552059_7.pdf>

⁴ National Law Center on Homelessness & Poverty. (2004). *Photo Identification Barriers Faced by Homeless Persons: The Impact of September 11*. Washington, DC. <https://www.nlchp.org/documents/ID_Barriers>

⁵ Kaiser Commission on Medicaid and the Uninsured. (2012). *Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion*. Washington, DC: The Henry J. Kaiser Family Foundation. <<https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8355.pdf>>

⁶ Kaiser Commission on Medicaid and the Uninsured. (2012). *Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion*. Washington, DC: The Henry J. Kaiser Family Foundation. <<https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8355.pdf>>

⁷ Peterson JA, S. R. (2010). Why don't out-of-treatment individuals enter methadone treatment programs? The International journal on drug policy. *International Journal of Drug Policy*, (21)1:36-42.

⁸ National Alliance for Model State Drug Laws. (2018). *States that Require ID Prior to Dispensing Controlled Substances or Non-Controlled Prescription Drugs*. Charlottesville: Office of National Drug Control Policy. <<http://www.namsdl.org/library/052D1242-E158-6B44-A6E69A0729BCDF0C>>

⁹ Montgomery, A. E., Szymkowiak, D., Marcus, J., Howard, P., & Culhane, D. P. (2016). Homelessness, Unsheltered Status, and Risk Factors for Mortality: Findings From the 100 000 Homes Campaign. *Public Health Reports*, 131(6), 765-772. doi:10.1177/0033354916667501

Whereas, The National Law Center on Homelessness and Poverty found that 54.1% of homeless individuals were denied housing or shelter due to lack of identification;¹⁰ and

Whereas, Recent national surveys have shown that 28% of homeless individuals do not get enough to eat, with 40% report going one or more days without food due to the inability to afford it;¹¹ and

Whereas, Lack of identification can prevent homeless individuals who qualify for Supplemental Nutrition Assistance Program (SNAP) benefits from accessing this service, as the application process requires personal identification; as a result, only 37% of the homeless population receives SNAP benefits;¹² and

Whereas, Lack of identification causes homeless individuals to delay care due to lack of insurance, and therefore has a systemic economic impact through increased emergency department utilization and presentation in more advanced disease stages;^{13,14} and

Whereas, The Medicaid application process includes verifying the applicant's Social Security Number, yet a replacement Social Security card requires a form of identification such as driver's license, state-issued non-driver identification card, or U.S. passport;^{15,16} and

Whereas, The average application fees to obtain a birth certificate and passport in the U.S. are \$15.81 and \$97, respectively;¹⁷ and

Whereas, A national study found that 36% of homeless individuals could not obtain a photo identification because they could not afford it;¹⁸ and

Whereas, The state of California passed a law allowing homeless individuals to obtain free photo identification, and a number of other state legislatures are in the process of doing the same;^{19,20,21,22,23} therefore be it

¹⁰ National Law Center on Homelessness & Poverty. (2004). *Photo Identification Barriers Faced by Homeless Persons: The Impact of September 11*. Washington, DC. <https://www.nlchp.org/documents/ID_Barriers>

¹¹ Rosen, J., Hoey, R., & Steed, T. (2000). Food stamp and SSI benefits: Removing access barriers for homeless people. *Clearinghouse Rev.*, 34, 679.

¹² Rosen, J., Hoey, R., & Steed, T. (2000). Food stamp and SSI benefits: Removing access barriers for homeless people. *Clearinghouse Rev.*, 34, 679.

¹³ Kaiser Commission on Key Facts. (2012). *The Uninsured And The Difference Health Insurance Makes*. Washington, DC: Henry J Kaiser Family Foundation. <<https://www.kff.org/health-reform/fact-sheet/the-uninsured-and-the-difference-health-insurance/>>

¹⁴ Hwang, S., & Henderson, M. J. (2010). Health care utilization in homeless people: translating research into policy and practice. *Agency for Healthcare Research and Quality Working Paper*, (10002). <https://meps.ahrq.gov/data_files/publications/workingpapers/wp_10002.pdf>

¹⁵ Wilkins, C., Burt, M. R., & Locke, G. (2014). *A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing*. Office of the Assistant Secretary for Planning and Evaluation.

¹⁶ Social Security Administration. (2018). *Social Security Administration*. Retrieved from Learn what documents you will need to get a Social Security Card: <https://www.ssa.gov/ssnumber/ss5doc.htm>

¹⁷ Department of Homeland Security Regulatory Evaluation. (2008). *Regulatory Evaluation for REAL ID Program*. Department of Homeland Security. <<https://www.regulations.gov/document?D=DHS-2006-0030-10704>>

¹⁸ National Law Center on Homelessness & Poverty. (2004). *Photo Identification Barriers Faced by Homeless Persons: The Impact of September 11*. Washington, DC. <https://www.nlchp.org/documents/ID_Barriers>

¹⁹ State of California Department of Motor Vehicles. (2018). Is There a Fee? *FFDL 6 Requirements for a California Identification Card*. California. <https://www.dmv.ca.gov/portal/dmv/detail/pubs/brochures/fast_facts/ffd06>

²⁰ Hawaii Senate Bill 11. S 346. 29th Legislature. (2017). <<https://legiscan.com/HI/bill/SB11/2017>>

²¹ An Act to provide identification to homeless youth and families. S.1906. 190th General Court of the Commonwealth of Massachusetts. (2017). <<https://malegislature.gov/Bills/190/H2737.html>>

²² Texas House Bill 3354. Relating to the fee for a driver's license or personal identification certificate for a homeless individual. Texas House of Representatives. 85th Legislature. (2017). <<https://legiscan.com/TX/text/HB3354/id/1559665>>

²³ West Virginia H.B. 2215. West Virginia House of Representatives. (2017).

<http://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=hb2215%20intr.htm&yr=2017&sesstype=RS&i=2215>

1 RESOLVED, That our American Medical Association recognize that among the homeless
 2 population, lack of identification serves as a barrier to accessing medical care and fundamental
 3 services that support health (New HOD Policy); and be it further
 4

5 RESOLVED, That our AMA support legislative and policy changes that streamline, simplify, and
 6 reduce or eliminate the cost of obtaining identification cards for the homeless population. (New
 7 HOD Policy)

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

Date Received: 09/21/18

RELEVANT AMA POLICY

The Mentally Ill Homeless H-160.978

(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.

Citation: BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16

Eradicating Homelessness H-160.903

Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless; (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis; (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness; and (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.

Citation: Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18

Maintaining Mental Health Services by States H-345.975

Our AMA:

1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.

Citation: (Res. 116, A-12; Reaffirmation A-15)

Subscriber Identification Cards H-185.944

Our AMA: (1) urges any pertinent official or governmental agency to require health insurance plans to issue identification cards to its subscribers which prominently identify the full legal name of the insured; name of the policy holder; identification numbers needed for claim submission; and the primary insurance company name with its appropriate mailing address; and (2) will advocate for legislative and regulatory sanctions against insurance companies which present obstacles to the timely filing of claims which result in the denial of benefits.

Citation: (Sub. Res. 716, A-10; Modified: Sub. Res. 715, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 908
(I-18)

Introduced by: Medical Student Section

Subject: Increasing Accessibility to Incontinence Products

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, As sales of adult incontinence products and baby diapers are projected to increase 48% and 2.6% respectively by 2020, more individuals and families in both populations face similar challenges to accessing necessary incontinence products;¹ and

Whereas, Lack of access to necessary incontinence products leads to prolonged use of soiled diapers, which precipitates health problems including recurrent urinary tract infections, diaper dermatitis, or exacerbation of eczema, leading to an increase in physician's office and emergency room visits;^{2,3} and

Whereas, Diaper need, defined as lacking the financial means to purchase an adequate supply of diapers, is a widespread issue affecting parents of all ethnicities and economic statuses, especially those living below the poverty line;⁴ and

Whereas, Among children using diapers, 23% are members of families earning less than 100% of the federal poverty level and an additional 23% live in families earning 100% to 200% of the federal poverty level;^{1,5} and

Whereas, The national average cost of diapers is \$936 annually, the equivalent of 14% of national average annual income;^{2,6} and

Whereas, Diaper need occurs more frequently in parents with mental health needs and contributes to parental stress and depression, factors which in turn have been known to increase the risk of a child's future behavioral, social, and emotional problems;^{3,4} and

Whereas, Adult incontinence product use is increasing, with the Urology Care Foundation estimating that 25% to 33% of all people in the U.S. suffer from some degree of urinary incontinence, with more than 50% of individuals over 65 having experienced incontinence;^{7,8} and

¹ Hymowitz C, Lochner-Coleman L. The Adult Diaper Market is About to Take Off. *Bloomberg*. February 11, 2016.

² Porter S, Steelfel L. Diaper need: A change for better health. *Pediatric Nursing*. 2015;41(3):141.

³ Fujimura T, Makino M, Takagi M, et al. The influence of incontinence on the characteristic properties of the skin in bedridden elderly subjects. *International Journal of Dermatology*. 2016;55(5):e234-240.

⁴ Raver C, Letourneau N, Scott J, D'Agostino H. Huggies every little bottom study: Diaper need in the US and Canada. Commissioned by Huggies®, a Kimberly-Clark company. 2010.

⁵ Diaper Need in America. National Diaper Bank Network. Accessed at <https://nationaldiaperbanknetwork.org/what-is-diaper-need/>.

⁶ Smith MV, Kruse A, Weir A, Goldblum J. Diaper need and its impact on child health. *Pediatrics*. 2013;132(2):253.

⁷ Urology Care Foundation: What is urinary incontinence? <https://www.urologyhealth.org/urologic-conditions/urinary-incontinence>. Accessed March 26, 2018.

⁸ Alameda County Board of Supervisors. Legislative Position Request Form. January 11, 2016.

Whereas, Of the 43 million Americans over 65 years of age, 9.4% are living below the federal poverty level;¹ and

Whereas, Seniors can expect to spend approximately \$1800 annually on adult diapers, and for low-income individuals this expense “can consume over 10 percent of their annual income”;⁹ and

Whereas, Studies have found that incontinence is detrimental to quality of life through its impact on relationships, self-esteem, employment, travel, and social activities;^{10,11,12} and

Whereas, 18 states have already eliminated sales tax on adult incontinence products and 13 states have eliminated sales tax on diapers by classifying them as medical supplies or clothing, exempting them as medical prescriptions, or having no sales tax at all;²¹ and

Whereas, 32 states still charge sales tax on adult incontinence products and 37 states still charge sales tax on diapers, with the sales tax as high as 7.25 percent;¹³ and

Whereas, Multiple pieces of state and federal legislation have proposed to increase access to adult incontinence products and diapers by removing state taxes, aiding low-income families in purchasing necessary products, and increasing insurance coverage through Medicare and Medicaid; however none have currently passed;^{14,15,16,17,18} and

Whereas, Our AMA already supports the removal of all sales tax on feminine hygiene products in order to increase access to necessary medical products, especially for those who live below the federal poverty line (H-270.953); therefore be it

RESOLVED, That our American Medical Association support increased access to affordable incontinence products. (New HOD Policy)

Fiscal note: Minimal - less than \$1,000.

Received: 09/24/18

⁹ Alameda County Board of Supervisors. Legislative Position Request Form. January 11, 2016.

¹⁰ Fisher, K. et al. Comparison of Recall and Daily Self-Report of Fecal Incontinence Severity. J Wound Ostomy Continence Nurs. 2008 Sept-Oct;35(5):515-20.

¹¹ Alimohammadian, M. et al. Suffering in silence: a community-based study of fecal incontinence in women. Int J Colorectal Dis. 2014 Mar;29(3):401-6.

¹² Halland, M. et al. Prevalence correlates and impact of fecal incontinence among older women. Dis Colon Rectum. 2013 Sep;56(9): 1080-6.

¹³ Weir, AM. Fifty state survey on the sales tax treatment of diapers. *National Diaper Bank Network*. January 9, 2017.

¹⁴ Hellmann J. Illinois lawmaker wants to cut tax on diapers, baby wipes. *Chicago Tribune*. February 6, 2015.

¹⁵ Coffey D. Legislators seek to make diapers exempt from state sales tax. *Hartford Courant*. February 2, 2015.

¹⁶ Vitale, Joseph F. State Concurrent Resolution No. 53. State of New Jersey. Introduced January 16, 2018.

¹⁷ Hygiene Assistance for Families of Infants and Toddlers Act of 2016, S. S.3070, 114 Cong. June 16, 2016.

¹⁸ Hygiene Assistance for Families of Infants and Toddlers Act of 2015, H.R. H.R.4055, 114th Cong. November 18, 2015.

RELEVANT AMA POLICY:

Tax Exemptions for Feminine Hygiene Products H-270.953

Our AMA supports legislation to remove all sales tax on feminine hygiene products.

Citation: Res. 215, A-16

Insurance Coverage for Complete Maternity Care H-185.997

Our AMA (1) reaffirms its policy of encouraging health insurance coverage for care of the newborn from the moment of birth;

(2) urges the health insurance industry and government to include in their plans, which provide maternity benefits, coverage for normal obstetrical care, and all obstetrical complications including necessary intrauterine evaluation and care of the unborn infant;

(3) urges the health insurance industry to offer such plans on the broadest possible basis;

(4) urges the health insurance industry to make available, on an optional basis, coverage for treatment associated with voluntary control of reproduction;

(5) will advocate for expanding coverage of maternity care to dependent women under the age of 26 on their parents' large group plans; and

(6) will advocate that individual, small and large group health plans provide 60 days of newborn coverage for all newborns born to participants in the plan.

Citation: (BOT Rep. M, CMS Rep. J, I-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 103, A-09; Appended: Res. 101, A-14)

Opposition to Proposed Budget Cuts in WIC and Head Start H-245.979

The AMA opposes reductions in funding for WIC and Head Start and other programs that significantly impact child and infant health and education.

Citation: (Res. 246, I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14)

Expanding Enrollment for the State Children's Health Insurance Program (SCHIP) H-290.971

Our AMA continues to support:

a. health insurance coverage of all children as a strategic priority;

b. efforts to expand coverage to uninsured children who are eligible for the State Children's Health Insurance Program (SCHIP) and Medicaid through improved and streamlined enrollment mechanisms;

c. the reauthorization of SCHIP in 2007; and

d. supports the use of enrollment information for participation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and/or the federal school lunch assistance program as documentation for SCHIP eligibility in order to allow families to avoid duplication and the cumbersome process of re-documenting income for child health coverage.

Citation: (Res. 118, A-07; CMS Rep. 1, A-07; Reaffirmation A-14)

Adequate Funding of the WIC Program H-245.989

Our AMA urges the U.S. Congress to investigate recent increases in the cost of infant formula, as well as insure that WIC programs receive adequate funds to provide infant formula and foods for eligible children.

Citation: (Res. 269, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10)

Dignity and Self Respect H-25.997

The AMA believes that medical care should be available to all our citizens, regardless of age or ability to pay, and believes ardently in helping those who need help to finance their medical care costs.

Furthermore, the AMA believes in preserving dignity and self respect of all individuals at all ages and believes that people should not be set apart or isolated on the basis of age. The AMA believes that the experience, perspective, wisdom and skill of individuals of all ages should be utilized to the fullest.

Citation: AMA President's Address, A-61; Reaffirmed: CLRPD C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Modified: CEJA Rep. 06, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 911
(I-18)

Introduced by: Resident and Fellow Section

Subject: Regulating Tattoo and Permanent Makeup Inks

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 Whereas, Almost a fourth of men and women between the age of 18 and 50 currently have a
2 tattoo¹; and

3
4 Whereas, The Food and Drug Administration regulates cosmetics, which are generally pigments
5 used on the surface of the skin, but does not regulate tattoo and permanent makeup inks which
6 are pigments injected with needles below the skin's surface²; and

7
8 Whereas, Some risks, such as the spread of infections through the use of unsterilized needles,
9 have long been known²; and

10
11 Whereas, The long term safety of permanent tattoo inks has not been previously studied²; and

12
13 Whereas, Research has also shown that some pigment migrates from the tattoo site to the
14 body's lymph nodes²; and

15
16 Whereas, Many pigments used in tattoo inks are industrial-grade colors suitable for printers' ink
17 or automobile paint²; and

18
19 Whereas, Azo pigments, the organic pigments making up about 60% of the colorants in tattoo
20 inks are not of health concern while chemically intact, they can degrade with the help of bacteria
21 or ultraviolet light and potentially can turn into cancer-causing primary aromatic amines; and

22
23 Whereas, Some surveys show that up to 50% of tattoo owners come to regret getting a tattoo;
24 and

25
26 Whereas, Lasers are often used to blast apart pigments, sending problematic degradation
27 products into the body and researchers do not know how the degradation products are
28 distributed in the body or how they get excreted; and

29
30 Whereas, A study by the Australian government's National Industrial Chemical's Notification and
31 Assessment Scheme (NICNAS) showed the presence of polycyclic aromatic hydrocarbons
32 (PAHs), a group of chemicals known to be carcinogens in more than one-fifth of 49 inks tested
33 and in 83% of the black inks tested³; and

34
35 Whereas, Tattoo inks may also contain potentially harmful metal impurities such as chromium,
36 nickel, copper, and cobalt; and

37
38 Whereas, Manufacturers of tattoo and permanent makeup inks in the United States are often
39 protected from divulging the ingredients of tattoo inks under the guise of considering them
40 'trademark secrets'; and

Whereas, In 2008, the Council of Europe, an organization focused on promoting human rights and the integration of regulatory functions in the continent, recommended policies to ensure the safety of tattoos and permanent makeup, which advocate the banning of sixty-two hazardous chemicals, as well as guidelines which include that tattoo and permanent makeup products should contain the following information on the packaging: the name and address of the manufacturer or the person responsible for placing the product on the market, the date of minimum durability⁴, the conditions of use and warnings, the batch number or other reference used by the manufacturer for batch identification, the list of ingredients according to their International Union of Pure and Applied Chemistry (IUPAC) name, CAS Number (chemical Abstract Service of the American Chemical Society) or Colour index (CI) number, and the guarantee of sterility of the contents⁵; and

Whereas, AMA policy H-440.909, "Regulation of Tattoo Artists and Facilities," currently only encourages the state regulation of tattoo artists and tattoo facilities to ensure adequate procedures to protect the public health, and encourages physicians to report all adverse reactions associated with tattooing to the Food and Drug Administration MedWatch program; and

Whereas, Current regulation of tattoo and permanent makeup inks in the United States performed at state or provincial levels generate a wide variety of guidelines and hygiene standards; therefore be it

RESOLVED, That our American Medical Association encourage the Food and Drug Administration to adopt regulatory standards for tattoo and permanent makeup inks that include at minimum the disclosures expected for injectable drugs and cosmetics and mandate that this information be available to both the body licensed to perform the tattoo and to the person receiving the tattoo (New HOD Policy); and be it further

RESOLVED, That our AMA study the safety of any chemical in tattoo and permanent makeup inks. (Directive to Take Action)

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

Received: 09/27/18

References:

¹ Laumann AE, Derick AJ. Tattoos and body piercings in the United States: a national data set. *Journal of the American Academy of Dermatology*. 2006 Sep 30;55(3):413-21.

² <https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm048919.htm>

³ <http://theconversation.com/one-in-five-tattoo-inks-in-australia-contain-carcinogenic-chemicals-63947>

⁴ Laumann AE, Derick AJ. Tattoos and body piercings in the United States: a national data set. *Journal of the American Academy of Dermatology*. 2006 Sep 30;55(3):413-21.

⁵ https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805d3dc4

RELEVANT AMA POLICY

H-440.909 Regulation of Tattoo Artists and Facilities

The AMA encourages the state regulation of tattoo artists and tattoo facilities to ensure adequate procedures to protect the public health; and encourages physicians to report all adverse reactions associated with tattooing to the Food and Drug Administration MedWatch program. (Res. 506, A-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16)

H-440.934 Adequacy of Sterilization in Commercial Enterprises

The AMA requests that state health departments ensure the adequacy of sterilization of instruments used in commercial enterprises (tattoo parlors, beauty salons, barbers, manicurists, etc.) because of the danger of exchange of infected blood-contaminated fluids. (Sub. Res. 409, I-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 912
(I-18)

Introduced by: Resident and Fellow Section
Subject: Comprehensive Breast Cancer Treatment
Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, The Women's Health and Cancer Rights Act of 1998 (WHCRA) mandates that insurance providers cover reconstructive procedures after mastectomy; and

Whereas, Some insurers have interpreted this language as only covering total mastectomies and not partial mastectomies or lumpectomies and thus deny coverage of reconstructive surgery for patients with deformities after lumpectomies and after radiation; and

Whereas, Breast conservation therapy is often an oncologically safe option for patients, which may leave the breast disfigured; and

Whereas, Radiation therapy in and of itself can lead to pain, fibrosis and deformity of a post-treatment breast; and

Whereas, Technology and techniques for correcting post-lumpectomy and post-radiation deformities have improved and increased, yet insurance interpretation of the WHCRA benefit may limit women's access to corrective surgery, oncoplastic reconstruction and fat grafting; and

Whereas, Breast reconstruction has been shown to significantly increase physical, social and sexual well-being¹; therefore be it

RESOLVED, That our AMA amend Policy H-55.973, "Breast Reconstruction," by addition and deletion as follows:

Our AMA: (1) believes that reconstruction of the breast for rehabilitation of the ~~postmastectomy cancer~~ post-treatment patient with in situ or invasive breast neoplasm should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided. (Modify Current HOD Policy)

References:

¹ Eltahir Y¹, Werners LL, Dreise MM, van Emmichoven IA, Jansen L, Werker PM, de Bock GH. Quality-of-life outcomes between mastectomy alone and breast reconstruction: comparison of patient-reported BREAST-Q and other health-related quality-of-life measures. [Plast Reconstr Surg](#). 2013 Aug;132(2):201e-209e. doi: 10.1097/PRS.0b013e31829586a7.

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

Received: 09/27/18

RELEVANT AMA POLICY

Breast Reconstruction H-55.973

Our AMA: (1) believes that reconstruction of the breast for rehabilitation of the postmastectomy cancer patient should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided.

CCB/CLRPD Rep. 3, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 913
(I-18)

Introduced by: Women Physicians Section

Subject: Addressing the Public Health Implications of Pornography

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 Whereas, Pornography is now recognized as a factor that directly contributes to and increases
2 all forms of violence against women as well as violence against children¹⁻¹⁷; and
3

4 Whereas, Exposure to pornography has been demonstrated to increase the likelihood of
5 perpetration of violence, including rape, domestic violence, and sexual harassment¹⁻¹⁷; and
6

7 Whereas, Literature shows that pornography demonstrably teaches beliefs about women,
8 children, and interpersonal relationships and teaches pathological and/or illegal sexual
9 behaviors (including rape, child molestation, prostitution, domestic violence, pedophilia, sexual
10 harassment, and some paraphilias)⁴⁻⁷; and
11

12 Whereas, Data demonstrate that pornography normalizes and promotes these pathological
13 and/or illegal behaviors^{1-3, 18-23}; and
14

15 Whereas, Digital access allows average age of first pornography exposure in the early teens
16 during a crucial stage of sexual development in young people⁸⁻¹⁷; and
17

18 Whereas, Pornography can also promote behaviors that increase the risk of sexually
19 transmitted diseases, gastrointestinal fissures/ruptures, post-traumatic stress disorder, sex
20 addiction, and paraphilias¹⁸⁻²³; and
21

22 Whereas, Four states (Florida, Idaho, Kansas, and Utah) have declared pornography to be a
23 public health risk²⁴; therefore be it
24

25 RESOLVED, That our American Medical Association support efforts to mitigate the negative
26 public health impacts of pornography as it relates to vulnerable populations, including but not
27 limited to women and children. (New HOD Policy)

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

Received: 09/28/18

References:

1. Marshall, W. L. (2000). Revisiting the use of pornography by sexual offenders: Implications for theory and practice. *The Journal of Sexual Aggression*, 6, 67-77.
2. Ohbuchi, K. Ikeda, T. & Takeuchi, G. (1994). Effects of violent pornography upon viewers rape myth beliefs: A study of Japanese males. *Psychology, Crime & Law*, 1, 71-81.
3. Allen, M., Emmers, T., Gebhardt, L., & Giery, M. (1995). Exposure to pornography and acceptance of the rape myth. *Journal of Communication*, 45, 1, 5-26.
4. Barak, A., Fisher, W. A., Belfry, S., & Lashambe, D. R. (1999). Sex, guys, and cyberspace: Effects of internet pornography and individual differences on men's attitudes toward women. *Journal of Psychology and Human Sexuality*, 11, 63-92.
5. Shope, J. (2004). When words are not enough: The search for the effect of pornography on abused women. *Violence Against Women*, 10, 1, 56-72.
6. Simmons, C. A., Lehmann, P. & Collier-Tennison, S. (2008). Linking male use of the sex industry to controlling behaviors in violent relationships: An exploratory analysis. *Violence Against Women*, 14, 406-417.
7. Sommers, E. K. & Check, J. V. P. (1987). An empirical investigation of the role of pornography in the verbal and physical abuse of women. *Violence and Victims*, 2(1), 189- 209.
8. Allen, M., D'Alessio, D., & Brezgel, K. (1995). A meta-analysis summarizing the effects of pornography II: Aggression after exposure. *Human Communication Research*, 22, 258- 283.
9. Boeringer, S. B. (1994). Pornography and sexual aggression: Associations of violent and nonviolent depictions with rape and rape proclivity. *Deviant Behavior*, 15, 289-304
10. Baron, L. & Straus, M. (1984). Sexual stratification, pornography, and rape in the United States. In N. Malamuth and E. Donnerstein (Eds) *Pornography and Sexual Aggression*. New York: Academic Press.
11. Bonino, S., Ciairano, S. Rabaglietti, E. & Cattelino, E. (2006). Use of pornography and self-reported engagement in sexual violence among adolescents. *European Journal of Developmental Psychology*, 3 (3), 265-288.
12. Ford, M. & Linney, J. A. (1995). Comparative analysis of juvenile sexual offenders, violent nonsexual offenders and status offenders. *Journal Of Interpersonal Violence*.
13. Marshall, W. L. (1988). The use of sexually explicit stimuli by rapists, child molesters and non-offenders. *Journal of Sex Research*, 25 (2), 267-288.
14. Koss, M., & Oros, C. (1982). Sexual experiences survey: A research instrument investigating sexual aggression and victimization. *Journal of Consulting and Clinical Psychology*, 50, 455-457.
15. Malamuth, N., Addison, T. & Koss, M. (2000). Pornography and sexual aggression: Are there reliable effects and can we understand them? *Annual Review of Sex Research*.
16. Bergen, R. & Bogle, K. (2000). Exploring the connection between pornography and sexual violence. *Violence and Victims*, 15, 3, 227-234.
17. Allen, M., D'Alessio, D., & Brezgel, K. (1995). A meta-analysis summarizing the effects of pornography II: Aggression after exposure. *Human Communication Research*, 22, 258- 283.
18. Weaver, J., Masland, J. L., & Zillmann, D. (1984). Effect of erotica on young men's aesthetic perception of their female sexual partners. *Perceptual and Motor Skills*, 58, 929- 930.
19. Zillmann, D. & Bryant, J. (1988). Pornography's impact on sexual satisfaction. *Journal of Applied Social Psychology*, 18, 438-453.
20. Fable, D. E. S., Johnson, A. E. & Kellman, H. (1997). Seeing masculine men, sexy women and gender differences: Exposure to pornography and cognitive constructs of gender. *Journal of Personality*, 65, 311-355.
21. Carroll, J. S., Padilla-Walker, L. M., Nelson, L. J., Olson, C. D., Barry, C. M., & Madsen, S. (2008). Generation XXX: Pornography acceptance and use among emerging adults. *Journal of Adolescent Research*, 23, 1, 6-30.
22. Zillmann, D. (1989). The effects of prolonged consumption of pornography. In D. Zillmann & J. Bryant (Eds.), *Pornography: Research Advances and Policy Considerations*
23. Zillmann, D. & J. Bryant. (1984). Effects of massive exposure to pornography. In Malamuth, N and Donnerstein, E. (Eds), *Pornography and sexual aggression*. San Diego, Academic Press. (pp. 127-158). Hillsdale, NJ: Erlbaum.
24. Is Pornography a 'Public Health Risk'? Available at <https://www.healthline.com/health-news/is-pornography-a-public-health-risk#1>.

RELEVANT AMA POLICY

Child Pornography H-60.990

The AMA (1) encourages and promotes awareness of child pornography issues among physicians; (2) promotes physician awareness of the need for follow-up psychiatric treatment for all victims of child pornography; (3) encourages research on child abuse (including risk factors, psychological and behavioral impact, and treatment efficacy) and dissemination of the findings; and (4) wherever possible, encourages international cooperation among medical societies to be alert to and intervene in child pornography activities.

Citation: BOT Rep. Z, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934

Our AMA:

- (1) Recognizes the positive role of the Internet in providing health information to children and youth.
- (2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
- (3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.
- (4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.
- (5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.

Citation: BOT Rep. 10, I-06; Modified: CSAPH Rep. 01, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 914
(I-18)

Introduced by: American Association of Public Health Physicians

Subject: Common Sense Strategy for Tobacco Control and Harm Reduction

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 Whereas, In the last few decades the United States has achieved remarkable success in
2 reducing the use of tobacco products and the associated negative health consequences; and
3

4 Whereas, From a common sense perspective, most would agree that in the case of an
5 individual smoking tobacco vs. e-cigs, the tobacco smoke produces more harmful tars and
6 toxins and individuals have the right to try to switch to e-cigs to reduce inhaling these; and
7

8 Whereas, Many physicians believe that because of the addictive - and possible acute
9 inflammatory effects of nicotine on the cardiovascular system - patients be encouraged to try to
10 stop smoking by other means before using e-cigs; and
11

12 Whereas, Teens and young adults, up to 21 years of age should avoid all nicotine delivery
13 products because of the risks of addiction and adverse effects on brain development; and
14

15 Whereas, The strong divide in the medical and public health communities regarding accessibility
16 of e-cigs, primarily rests on "population" based disagreements and speculations regarding
17 whether they are effective for the complete abstinence from smoking cigarettes, will prove
18 effective over the long term in reducing tobacco use and whether they play a role in addicting
19 youth to nicotine, and possibly tobacco; and
20

21 Whereas, Recent debate over the role of inhalation products in further tobacco harm reduction
22 has created confusion within the profession and public, rather than the sage guidance they
23 deserve; and
24

25 Whereas, E-cigarettes have been shown to be effective in reducing tobacco use in some adults
26 justifying them as a cessation option, yet, it is also prudent to assure minors are banned from
27 purchasing potentially addictive nicotine substances; and
28

29 Whereas, Although abstinence of inhalation of other than prescribed drugs is the healthiest
30 practice, youth continue to experiment with inhalation of substances such as cannabis, corn silk,
31 hookah mixtures and non-drug containing, relatively toxic free, often flavored, "vape" products;
32 therefore be it

1 RESOLVED, That our American Medical Association advocate for a "protect adult choice and
2 youth's health" "common sense" tobacco strategy (with a report back to the House of Delegates
3 annually) under which:
4

- 5 • Current educational, promotional and policy initiatives (e.g. taxation) to reduce the
6 use of tobacco products by inhalation and orally would continue, including
7 advocating for the prohibition of the sale of ALL nicotine containing products to
8 individuals under 21 years unless via prescription for medical purposes.
9
- 10 • E-cigarettes (non-tobacco products containing nicotine) would be accessible at an
11 affordable price to adults who wish to use them, and would be available to
12 individuals below 21 years of age only as part of state sanctioned tobacco
13 cessation activities. States and local jurisdictions would be free to require vendors
14 to post warnings regarding the possible health risks of the use of nicotine inhalation
15 products.
16
- 17 • Non-nicotine, non-drug containing vaping and other inhalation products would not
18 be considered tobacco products, but would be monitored by state and local
19 jurisdictions as any other personal use product regarding safety and public
20 accommodation. (New HOD Policy)

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

Received: 09/28/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 915
(I-18)

Introduced by: American College of Emergency Physicians

Subject: Mandatory Reporting

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, In general, mandatory reporting for conditions should seek to mitigate against risk to others in society as a result of their interaction with the patient triggering mandatory reporting, such as in cases of infectious disease, or should assist uniquely vulnerable populations, such as victims of child abuse or domestic violence; and

Whereas, Physician reporting requirements are increasingly being mandated for conditions that do not pose a public health threat or serve to protect vulnerable populations, including California's recent passage of a law requiring physicians and other health care providers diagnosing or providing treatment to Parkinson's disease patients to report each case of Parkinson's disease to the state Department of Public Health¹; and

Whereas, Zealous commitment to alleviate specific conditions should not dictate broad-based public mandates; and

Whereas, Compliance with mandatory reporting requirements substantially adds to the significant and growing administrative burden borne by physicians and other health care providers; therefore be it

RESOLVED, That our American Medical Association oppose mandated reporting of entire classes of patients and specific diagnoses unless compelling evidence exists to demonstrate that a serious public health and/or safety risk will be mitigated as a result of such reporting.
(New HOD Policy)

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

Received: 10/10/18

References:

¹ California HSC-Division 102-Part 2-Chapter 1.6

https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=102.&title=&part=2.&chapter=1.6.&article=

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 916
(I-18)

Introduced by: American Thoracic Society, Society of Critical Care Medicine,
American College of Chest Physicians

Subject: Ban on Tobacco Flavoring Agents with Respiratory Toxicity

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, The Food and Drug Administration (FDA), under the family smoking prevention and tobacco control act, has authority to regulate all tobacco products, including electronic nicotine delivery systems (ENDS) such as e-cigarettes; and

Whereas, END use has dramatically increased among youth; and

Whereas, Youth report that END flavors are a compelling reason youth try and continue to use END products; and

Whereas, FDA Commissioner Scott Gottlieb MD has called the youth rise in e-cigarette use an “epidemic”; and

Whereas, Several flavoring agents currently use in END products, including diacetyl, 2,3 pentanedione, acetoin, cinnamaldehyde, benzaldehyde, eugenol, vanillin/ethyl vanillin, and menthol, have known toxicity when exposed to the lung; and

Whereas, Other flavoring agents have been tested for oral and digestive tract exposure but have not yet been tested adequately for inhalation and respiratory exposure; therefore be it

RESOLVED, That our American Medical Association call for the immediate ban on flavoring agents in ENDS and other tobacco products that have known respiratory toxicity including but not limited to diacetyl, 2,3 pentanedione, acetoin, cinnamaldehyde, benzaldehyde, eugenol, vanillin/ethyl vanillin, and menthol (Directive to Take Action); and be it further

RESOLVED, That our AMA urge the Food and Drug Administration (FDA) to require comprehensive testing of flavoring agents used in electronic nicotine delivery systems (ENDS) and other tobacco products to assess the potential negative health effects of chronic exposure to these flavoring agents. (Directive to Take Action)

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

Received: 10/11/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 917
(I-18)

Introduced by: American Thoracic Society, Society of Critical Care Medicine,
American College of Chest Physicians

Subject: Protect and Maintain the Clean Air Act

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, The scientific literature clearly documenting that exposure to air pollution results in significant adverse health effects including premature mortality, reduced lung function, exacerbation of respiratory disease, missed school and work days, increased medication use and other health effects; and

Whereas, The Clean Air Act, which has been implemented and enforced by the Environmental Protection Agency, has made significant improvements in US air quality that have led to measurable improvements in public health; and

Whereas, The “New Source Review” section of the Clean Air Act (CAA) is an important section of the law that requires that when a major pollution emitting facility makes changes to its equipment or operations that are expected to result in increased annual pollution emissions, the facility must install pollution control emissions equipment; and

Whereas, Coal and oil-fired power plants are a major source of both greenhouse gas emissions and air pollution emissions in the U.S.; and

Whereas, The Administration has issued a proposed rule, called Affordable Clean Energy rule, to regulate greenhouse gas (GHG) emissions from coal and oil-fired power plants that would result in a mere 1.5% reduction in GHG emissions, but would allow power plants to increase annual emissions of other pollutants including particulate matter, sulfur oxides and nitrogen oxides without having to meet the CAA's New Source Review requirements; and

Whereas, The increase in annual air pollution emissions will result in an increase in adverse health effects for those living in the US; and

Whereas, The EPA estimates implementation of the proposed rule will result in an additional 1,400 premature deaths annually, 48,000 additional asthma attacks, and 21,000 missed school days posing a significant impact on an individual's quality of life and financial stability; and

Whereas, Cost effective pollution-reduction technology exists today and is in operation at power plants across the US; therefore be it

RESOLVED, That our American Medical Association oppose provisions of the Affordable Clean Energy proposed rule that would allow power plants to avoid complying with new source review requirements to install air pollution control equipment when annual pollution emissions increase (New HOD Policy); and be it further

- 1 RESOLVED, That our AMA send a letter to the Environmental Protection Agency (EPA)
- 2 expressing our opposition to EPA's Affordable Clean Energy rule and its proposed amendments
- 3 of the New Source Review requirements under the Clean Air Act. (Directive to Take Action)

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

Received: 10/11/18

RELEVANT AMA POLICY

Support the Health Based Provisions of the Clean Air Act H-135.950

Our AMA (1) opposes changes to the New Source Review program of the Clean Air Act; (2) urges the Administration, through the Environmental Protection Agency, to withdraw the proposed New Source Review regulations promulgated on December 31, 2002; and (3) opposes further legislation to weaken the existing provisions of the Clean Air Act.

Citation: (Res. 417, A-03; Reaffirmation A-05; Reaffirmation I-11)

Clean Air H-135.991

(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.

(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.

(3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants.

(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.

(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health.

Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health.

Citation: (BOT Rep. R, A-82; Reaffirmed: CLRPD Rep. A, I-92; Amended: CSA Rep. 8, A-03; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation I-09; Reaffirmation A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 918
(I-18)

Introduced by: Indiana

Subject: Allergen Labeling on Food Packaging

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 Whereas, Anaphylactic food allergies continue to increase in prevalence; and

2
3 Whereas, An anaphylactic food allergy may be fatal; and

4
5 Whereas, There has been a documented fatal anaphylactic food reaction in a teenager who
6 unsuspectingly ate from packaging that resembled packaging of other, non-allergenic, food
7 products; and

8
9 Whereas, Current Food and Drug Administration (FDA) food labeling guidelines are inadequate
10 to prevent accidental allergen exposure when products are contained in familiar packaging that
11 usually does not contain common allergens; therefore be it

12
13 RESOLVED, That our American Medical Association petition the Food and Drug Administration
14 to pursue more obvious labeling on food packaging containing the eight most common food
15 allergens: milk, eggs, peanuts, tree nuts, wheat, soy, fish and crustacean shellfish. (Directive to
16 Take Action)

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

Received: 10/09/18

RELEVANT AMA POLICY

Support for Nutrition Label Revision and FDA Review of Added Sugars D-150.974

1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period.
2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA).
3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.

Citation: (Res. 422, A-14)

Preventing Allergic Reactions in Food Service Establishments D-440.932

Our American Medical Association will pursue federal legislation requiring restaurants and food establishments to: (1) include a notice in menus reminding customers to let the staff know of any food allergies; (2) educate their staff regarding common food allergens and the need to remind customers to inform wait staff of any allergies; and (3) identify menu items which contain any of the major food allergens identified by the FDA (in the Food Allergen Labeling and Consumer Protection Act of 2004) and which allergens the menu item contains.

Citation: (Res. 416, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 919
(I-18)

Introduced by: Indiana

Subject: Opioid Mitigation

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 Whereas, Indiana has suffered the scourge of opioid abuse, addiction, overdose and death.
2 There has been much suffering among family and friends of Hoosier opioid users; and
3

4 Whereas, Clark County, IN, has enjoyed some success in lowering overdose deaths with
5 several identified strategies that help mitigate the issue; and
6

7 Whereas, Huntington, WV, has enjoyed more success in its strategies to combat opioids. They
8 can serve as an example of best practices, and one of the most effective tools is an opioid
9 overdose team. This team visits the home of someone who has been discharged from the
10 emergency department with a diagnosis of opioid overdose. This visit occurs typically on the
11 day of the overdose. The goal of the visit is to educate the individual about all the services
12 available for opioid users in Huntington and its associated Cabell County. The most important
13 information presented relates to options for drug rehabilitation. Encouragement and support are
14 also part of the message; and
15

16 Whereas, The success of the West Virginia program is also rooted in generous funding from the
17 city, county and state for the services described, as well as in a strong sense of community,
18 collaboration and cooperation between the organizations dealing with this difficult issue; and
19

20 Whereas, Local and state political leaders and legislative bodies should support such a program
21 with adequate funding to help ensure its success. We are dealing with a pay-now or pay-more-
22 later situation. Premature death of an individual from an opioid overdose has economic
23 consequences in the millions of dollars per individual, as well as stress and psychological
24 effects on the family. There is also an increase in costs due to more crime, policing, court cases
25 and incarcerations; therefore be it

1 RESOLVED, That our American Medical Association review the following opioid mitigation
2 strategies based on their effectiveness in Huntington, WV, and Clark County, IN, and provide
3 feedback concerning their utility in dealing with opioids:
4

5 (1) The creation of an opioid overdose team that decreases the risk of future
6 overdose and overdose death, increases access to opioid-related services
7 and increases the likelihood that an individual will pursue drug rehabilitation.
8

9 (2) A needle exchange program that is open multiple days a week and is
10 mobile offers not only a source for needles but also Narcan, other supplies,
11 health care and information.
12

13 (3) The creation of a drug court that allows a judge to have greater flexibility in
14 determining the legal consequences of an arrest for an opioid-related crime. It
15 also allows for the judicial patience necessary to deal with the recidivism of
16 this population.
17

18 (4) Offering more acute-care inpatient drug rehab beds, although those ready
19 for treatment need to be willing to travel significant distances to get to a
20 treatment bed.
21

22 (5) Make available Narcan intranasal spray OTC through pharmacies and the
23 syringe exchange, overdose team, etc.
24

25 (6) Encourage prevention education in K-12 programs that uses multiple
26 media with anti-drug messaging delivered in the school system but also in the
27 home. (Directive to Take Action)

Fiscal Note: Estimated cost to implement resolution is \$130K.

Received: 10/09/18

RELEVANT AMA POLICY

<https://policysearch.ama-assn.org/policyfinder/search/opioids/relevant/1/>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 920
(I-18)

Introduced by: Michigan

Subject: Continued Support for Federal Vaccination Funding

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 Whereas, The “CDC estimates that vaccination of children born between 1994 and 2013 will
2 prevent 322 million illnesses; will help avoid 732,000 deaths; and will save nearly \$1.4 trillion in
3 total societal costs;” and
4

5 Whereas, Section 317 of the Public Health Service Act provides federal funding to cover
6 vaccines for uninsured and underinsured individuals as well as those with insurance during
7 times of emergency outbreaks; and
8

9 Whereas, The federal funding through the Section 317 program also serves a crucial role in
10 vaccine development and improvement, conducting community outreach and education, and
11 leading the responses to disease outbreaks; and
12

13 Whereas, The Section 317 program is different from the Vaccines for Children program in that
14 Section 317 funded vaccines can be given to under-insured individuals receiving vaccines at a
15 health care institution that is not a Federally Qualified Health Center nor deputized; and
16

17 Whereas, An independent study demonstrated that an increase in Section 317 funding by \$10
18 per individual resulted in a 1.6 percent increase in vaccination coverage between 1997 and
19 2003; and
20

21 Whereas, In the Fiscal Year 2018 President's Budget Proposal and House of Representatives
22 Appropriations, \$521,000,000 and \$557,000,000, respectively, is appropriated for funding for
23 the Section 317 Immunization program, a decrease from \$607,000,000 allocated in Fiscal Year
24 2017; and
25

26 Whereas, While it is important for funding to remain, at minimum, the same; ideally, it would
27 increase to support public health efforts at vaccination and safety during times of outbreaks
28 across individual states and the country; therefore be it
29

30 RESOLVED, That our American Medical Association release a public statement of support for
31 federal vaccination funding efforts such as Section 317, and actively advocate for sustained
32 funding. (Directive to Take Action)

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

Received: 10/10/18

SOURCES

1. ChildVaxView Interactive!. Centers for Disease Control and Prevention website. <https://www.cdc.gov/vaccines/imz-managers/coverage/childvaxview/data-reports/index.html>. Updated November 3, 2017. Accessed February 13, 2018.
2. Key Health Data About Michigan. Trust for America's Health website. <http://healthyamericans.org/states/?stateid=MI#section=1,year=2017,code=undefined>
3. http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2976_82305_82310-447907--,00.html. Accessed February 13, 2018.
4. Justification of Estimates for Appropriation Committees. Department of Health and Human Services, Centers for Disease Control and Prevention, Fiscal Year 2017; 45.
5. Questions Answered on Vaccines Purchased with 317 Funds. Centers for Disease Control and Prevention website. <https://www.cdc.gov/vaccines/imz-managers/guides-pubs/qa-317-funds.html>. Updated July 19, 2013. Accessed February 13, 2018.
6. FY 2018 Labor-HHS-Education Appropriations Bill Centers for Disease Control and Prevention Immunization. 317 Coalition website. http://www.317coalition.org/documents/FY18_317IssueBrief.pdf. Accessed February, 13, 2018.
7. Jarris P, Dolen V. Section 317 Immunization Program: Protecting a National Asset. Public Health Reports. 2013;128(2): 96-98. DOI: 10.1177/003335491312800204
8. Rein DB, Honeycutt AA, Rojas-Smith L, Hersey JC. Impact of the CDC's Section 317 Immunization Grants Program Funding on Childhood Vaccination Coverage. American Journal of Public Health. Oct 2006; 96(9): 1548-1553. DOI: 10.2105/AJPH.2005.078451
9. FY2018 President's Budget Proposal NACCHO Priority Public Health Program Funding. National Association of County and City Health Officials website. <https://www.naccho.org/uploads/downloadable-resources/FY2018-Pres-Budget-summary.pdf>. Accessed February 13, 2018.
10. Legislative Update. 317 Coalition Removing Financial Barriers to Immunization website. <http://www.317coalition.org/update.html>. Accessed February 13, 2018.

RELEVANT AMA POLICY

Financing of Adult Vaccines: Recommendations for Action H-440.860

1. Our AMA supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States:

Provider-related

- a. Develop a data-driven rationale for improved vaccine administration fees.
- b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
- c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
- d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

Federal-related

- a. Increase federal resources for adult immunization to: (i) Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations; (ii) Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered; (iii) Fund an adequate universal reimbursement rate for all federal and state immunization programs.
- b. Optimize use of existing federal resources by, for example: (i) Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding; (ii) Capitalizing on public health preparedness funding.
- c. Ease federally imposed immunization burdens by, for example: (i) Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B; (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient; (iii) Simplifying the reimbursement process to eliminate payment-related barriers to immunization.

d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.

State-related

- a. State Medicaid programs should increase state resources for funding vaccines by, for example: (i) Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees; (ii) Establishing and requiring payment of a minimum reimbursement rate for administration fees; (iii) Increasing state contributions to vaccination costs; and (iv) Exploring the possibility of mandating immunization coverage by third party payers.
- b. Strengthen support for adult vaccination and appropriate budgets accordingly.

Insurance-related

- 1. Provide assistance to providers in creating efficiencies in vaccine management by: (i) Providing model vaccine coverage contracts for purchasers of health insurance; (ii) Creating simplified rules for eligibility verification, billing, and reimbursement; (iii) Providing vouchers to patients to clarify eligibility and coverage for patients and providers; and (iv) Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines.
- b. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
- c. Improve accountability by adopting performance measurements.
- d. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan.
- e. Provide incentives to encourage providers to begin immunizing by, for example: (i) Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations; (ii) Simplifying payment to and encouraging immunization by nontraditional providers; (iii) Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

Manufacturer-related

Market stability for adult vaccines is essential. Thus: (i) Solutions to the adult vaccine financing problem should not deter research and development of new vaccines; (ii) Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets; (iii) Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines; (iv) Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.

Citation: (CSAPH Rep. 4, I-08; Reaffirmation I-10; Reaffirmation: I-12; Reaffirmation I-14)

Reimbursement for Influenza Vaccine H-440.848

Our AMA: (1) will work with third party payers, including the Centers for Medicare and Medicaid Services, to establish a fair reimbursement price for the flu vaccine; (2) encourage the manufacturers of influenza vaccine to publish the purchase price by June 1st each year; (3) shall seek federal legislation or regulatory relief, or otherwise work with the federal government to increase Medicare reimbursement levels for flu vaccination and other vaccinations.

Citation: (CSAPH Rep. 5, I-12)

Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875

1. It is AMA policy that all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR).
2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.
3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.
4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely distribution of ACIP-recommended vaccines to providers).
5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines.
6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.
7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.
8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.
9. Until compliance of AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.
10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines.

Citation: BOT Action in response to referred for decision Res. 524, A-06; Reaffirmation A-07; Appended: Res. 531, A-07; Reaffirmation A-09; Reaffirmed: Res. 501, A-09; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 422, A-11; BOT action in response to referred for decision Res. 422, A-11; Reaffirmation: I-12; Appended: Res. 227, I-12; Appended: Res. 824, I-14; Reaffirmed: Res. 411, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 921
(I-18)

Introduced by: Michigan

Subject: Food Environments and Challenges Accessing Healthy Food

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 Whereas, Over 29.7 million Americans live at or below 200 percent of the federal poverty level;
2 and

3
4 Whereas, Food security, diversity, and accessibility significantly impact individual and
5 community health; and

6
7 Whereas, A food desert is defined by the United States Department of Agriculture as a low-
8 income census tract where a significant number or share of residents have low access to a full-
9 service supermarket or grocery store, where low access is defined as residing more than 1 mile
10 from a full-service grocery store in urban areas and more than 10 miles from a full-service
11 grocery store in rural areas; and

12
13 Whereas, A food swamp can be characterized as areas where large relative amounts of energy-
14 dense snack foods inundate healthy food options or geographic areas with disproportionate
15 access to energy-dense, nutrient-poor foods; and

16
17 Whereas, A food mirage is a food environment distinct from food deserts in that healthy foods
18 may be available, but prices are beyond the means of those living nearby, making them
19 functionally equivalent to food deserts in that long journeys are needed to obtain food; and

20
21 Whereas, Food mirages are often invisible to conventional food desert assessment criteria due
22 to their proximity to healthy food options and thereby causing an illusion of access; and

23
24 Whereas, Conventional food desert assessments can inaccurately assume that grocery store
25 prices are reasonably similar, and that any full-service grocery store can serve consumers
26 equally well as points of access to healthy foods; and

27
28 Whereas, Though grocery store food can be relatively affordable compared to those of other
29 stores, it does not equate to being affordable for low-income residents who may be struggling to
30 consistently put food on the table; and

31
32 Whereas, Not only is price at times the strongest motivator for deciding where one shops or if
33 one is even able to shop, consideration for whether their choice stores accept federal
34 assistance dollars further sways their decisions; and

35
36 Whereas, A food outlet's choice of inventory and impact on a community's food diversity are
37 influenced heavily by community interest and consumer financial capability, and

Whereas, A food oasis is best described as “any place where people have the best possible access to healthy options and eating environments” where “access includes financial and physical access to healthy foods and drinks that are high quality, affordable, culturally acceptable, and meet the nutritional needs of the people in the community;” and

Whereas, Previous studies examining food oases effectively consider them the gold standard for communities to strive for; and

Whereas, American Medical Association (AMA) policies such as D-150.978 and 150.034MSS provide no guidance on identification of food oases, which makes it more difficult to differentiate between communities that may or may not have access to healthy, affordable food alternatives; and

Whereas, Although these AMA policies aim to address disparities secondary to functional access to food including cost, ethnic preferences, and education, these alone are unlikely to resolve the distinct challenges faced by food swamps and food mirages; and

Whereas, By accounting only for food deserts, which are measured in literature and policy by physical proximity to healthy foods, and omitting consideration of consumer socioeconomic or cultural factors, “food environment literature takes on a singular narrative and a narrow conceptual representation of the barriers people face to accessing food”; therefore be it

RESOLVED, That our American Medical Association work with appropriate stakeholders to advocate for the study of the national prevalence and impact of food mirages, food swamps, and food oases as food environments distinct from food deserts. (Directive to Take Action)

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

Received: 10/10/18

RELEVANT AMA POLICY

Sustainable Food D-150.978

Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.

Citation: (CSAPH Rep. 8, A-09; Reaffirmed in lieu of Res. 411, A-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 205, A-12; Modified: Res. 204, A-13; Reaffirmation A-15)

Reform the US Farm Bill to Improve US Public Health and Food Sustainability H-150.932

Reform the US Farm Bill to Improve US Public Health and Food SustainabilityOur AMA supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders.

Citation: (Res. 215, A-13)

National Nutritional Guidelines for Food Banks and Pantries H-150.930

Our AMA: (1) supports the use of existing national nutritional guidelines for food banks and food pantries and (2) will promote sustainable sourcing of healthier food options and the dissemination of user-friendly resources and education on healthier eating for food banks and food pantries.

Citation: Res. 413, A-14; Appended: Res. 415, A-17

SOURCES

1. Ploeg M Ver, Breneman V, Farrigan T, et al. Access to Affordable and Nutritious Food: Measuring and Understanding Food Deserts and Their Consequences. 2009;(June). http://www.ers.usda.gov/media/242675/ap036_1_.pdf.
2. Food H, Initiative F, Group W, Markets N, Credit T. Definition of a Food Desert Definitions of Indicators Mapped to Food Deserts. http://www.ers.usda.gov/dataFiles/Food_Access_Research_Atlas/Download_the_Data/Archived_Version/archived_documentation.pdf.
3. Luan H, Law J, Quick M. Identifying food deserts and swamps based on relative healthy food access: A spatio-temporal Bayesian approach. *Int J Health Geogr*. 2015;14(1):1-11. doi:10.1186/s12942-015-0030-8.
4. Sushil Z, Vandevijvere S, Exeter DJ, Swinburn B. Food swamps by area socioeconomic deprivation in New Zealand: a national study. *Int J Public Health*. 2017;62(8):869-877. doi:10.1007/s00038-017-0983-4.
5. Cooksey-Stowers K, Schwartz MB, Brownell KD. Food swamps predict obesity rates better than food deserts in the United States. *Int J Environ Res Public Health*. 2017;14(11):1-20. doi:10.3390/ijerph14111366.
6. Colón-Ramos U, Monge-Rojas R, Cremm E, Rivera IM, Andrade EL, Edberg MC. How Latina mothers navigate a “food swamp” to feed their children: A photovoice approach. *Public Health Nutr*. 2017;20(11):1941-1952. doi:10.1017/S1368980017000738.
7. Breyer B, Voss-Andreae A. Food mirages: Geographic and economic barriers to healthful food access in Portland, Oregon. *Heal Place*. 2013;24:131-139. doi:10.1016/j.healthplace.2013.07.008.
8. Wiebe K, Distasio J. Confronting the Illusion: Developing a Method to Identify Food Mirages and Food Deserts in Winnipeg. *IUS In-br Ser*. 2016;(June).
9. Tach L, Amorim M. Constrained, Convenient, and Symbolic Consumption: Neighborhood Food Environments and Economic Coping Strategies among the Urban Poor. *J Urban Heal*. 2015;92(5):815-834. doi:10.1007/s11524-015-9984-x.
10. Sullivan DM. From Food Desert to Food Mirage: Race, Social Class, and Food Shopping in a Gentrifying Neighborhood. *Adv Appl Sociol*. 2014;4(1):30-35. doi:10.4236/aasoci.2014.41006.
11. MacNeill L, Elliott S, Hardison-Moody A, Bowen S. Black and Latino Urban Food Desert Residents' Perceptions of Their Food Environment and Factors That Influence Food Shopping Decisions. *J Hunger Environ Nutr*. 2017;12(3):375-393. doi:10.1080/19320248.2017.1284025.
12. Dubowitz T, Ghosh-Dastidar M, Cohen DA, et al. Diet And Perceptions Change With Supermarket Introduction In A Food Desert, But Not Because Of Supermarket Use. *Health Aff (Millwood)*. 2015;34(11):1858-1868. doi:10.1377/hlthaff.2015.0667.
13. Ghosh-Dastidar M, Hunter G, Collins RL, et al. Does opening a supermarket in a food desert change the food environment? *Health Place*. 2017;46:249-256. doi:10.1016/j.healthplace.2017.06.002.
14. Washington State Department of Health. Food Oasis. Community and Environment. <https://www.doh.wa.gov/CommunityandEnvironment/Food/AccessToHealthyFoods/FoodOasis>. Published 2017.
15. Bridle-Fitzpatrick S. Food deserts or food swamps?: A mixed-methods study of local food environments in a Mexican city. *Soc Sci Med*. 2015;142:202-213. doi:10.1016/j.socscimed.2015.08.010.
16. Walker RE, Block J, Kawachi I. Do residents of food deserts express different food buying preferences compared to residents of food oases? A mixed-methods analysis. *Int J Behav Nutr Phys Act*. 2012;9(c):1-13. doi:10.1186/1479-5868-9-41.
17. Walker RE. FOOD DESERT VERSUS FOOD OASIS : AN EXPLORATION OF RESIDENTS ' PERCEPTIONS OF FACTORS INFLUENCING FOOD BUYING PRACTICES. 2009.
18. American Medical Association. AMA-MSS Digest of Policy Actions. <https://www.ama-assn.org/sites/default/files/media-browser/mss-digest-032017.pdf>. Published 2017.

Not for consideration

Resolutions not for consideration

- 601 Creation of an AMA Election Reform Committee
- 602* AMA Policy Statement with Editorials
- 907 Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing
- 909 Use of Person-Centered Language
- 910 Shade Structures in Public and Private Planning and Zoning Matters

* contained in the Handbook Addendum

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(I-18)

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

Subject: Creation of an AMA Election Reform Committee

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

1 Whereas, Members of our AMA House of Delegates cherish our democratic process; and

2
3 Whereas, Our current election and voting process for AMA officers and council positions
4 consumes a lot of time and financial resources; and

5
6 Whereas, Election reform would allow for more time for policy and debate during HOD sessions;
7 and

8
9 Whereas, Cost barriers are often an impediment to candidate elections; and

10
11 Whereas, There are significant technological advances that could allow for an expedited
12 process of elections and debate; therefore be it

13
14 RESOLVED, That our American Medical Association appoint a House of Delegates Election
15 Reform Committee to examine ways to expedite and streamline the current election and voting
16 process for AMA officers and council positions (Directive to Take Action); and be it further

17
18 RESOLVED, That such HOD Election Reform Committee consider, at a minimum, the following
19 options:

- 20
21 - The creation of an interactive election web page;
22 - Candidate video submissions submitted in advance for HOD members to view;
23 - Eliminate all speeches and concession speeches during HOD deliberations, with the
24 exception of the President-Elect, Speaker and Board of Trustee positions;
25 - Move elections earlier to the Sunday or Monday of the meeting;
26 - Conduct voting from HOD seats (Directive to Take Action); and be it further

27
28 RESOLVED, That our AMA review the methods to reduce and control the cost of campaigns
29 (Directive to Take Action); and be it further

30
31 RESOLVED, That the HOD Election Reform Committee report back to the HOD at the 2019
32 Interim Meeting with a list of recommendations. (Directive to Take Action)

Fiscal Note: Estimated cost to implement resolution is between \$15K-\$25K.

Received: 09/25/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(I-18)

Introduced by: Indiana

Subject: AMA Policy Statement with Editorials

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

- 1 Whereas, Freedom of speech is essential and all side of an issue deserve to be discussed; and
2
3 Whereas, Our AMA has good policy on most medical issues; and
4
5 Whereas, The Aug. 22-29, 2017, *JAMA* published an editorial on MOC contrary to AMA policy;
6 therefore be it
7
8 RESOLVED, Our American Medical Association include a policy statement after all editorials in
9 which policy has been established to clarify our position. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 10/09/18

RELEVANT AMA POLICY

AMA Publications G-630.090

AMA policy on its publications includes the following:

(1) JAMA and other AMA scientific journals should display a disclaimer in prominent print that the editorial views are not necessarily AMA policy.

(2) Our AMA, in all of its publications and correspondence, will use the correct title for the medical specialist.

(3) Our AMA recommends that medical journal articles using acronyms should have a small glossary of acronyms and phrases displayed prominently in the article.

(4) The House of Delegates affirms that JAMA and The JAMA Network journals shall continue to have full editorial independence as set forth in the AMA Editorial Governance Plan.

Res. 294, A-90 BOT Rep. G, A-91 BOT Rep. VV, I-92 BOT Rep. PP, A-93 Res. 622, I-96 Res. 612, A-97 Reaffirmed: Sunset Report and Appended: BOT Rep. 22, I-00 Consolidated: CLRPD Rep. 3, I-01 Appended: BOT Rep. 32, A-04 Modified: CCB/CLRPD Rep. 3, A-12 Modified: Speakers Rep., A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 907
(I-18)

Introduced by: Medical Student Section

Subject: Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, Surveys indicate that the majority (95% of males and 75% of females) of individuals have at least some lifetime exposure to pornographic material;¹ and

Whereas, The Problematic Pornography Consumption Scale (PPCS) was developed to distinguish between nonproblematic and problematic pornography use and when the PPCS was used in a study of 772 respondents, 3.6% of pornography users belonged to the at-risk group;² and

Whereas, Individuals suffering from problematic pornography use may have impaired daily functioning that includes hardship on romantic relationships and job loss due to the inability to control urges to view pornography at work;³ and

Whereas, The Kinsey Institute survey found that 9% of porn viewers reported that they had tried unsuccessfully to stop;³ and

Whereas, There is emerging evidence that the meso-limbic-frontal regions of the brain that are associated with reward pathways exhibit dopaminergic and serotonergic neurotransmitter dysregulation similar to that in addictive disorders;^{4,5} and

Whereas, Several studies have linked problematic pornography use to increased incidence of erectile dysfunction⁶ and higher rates of domestic violence;⁷⁻⁹ and

Whereas, During the drafting of the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) in 2012, it was proposed that the addictive disorders category develop a new diagnosis called hypersexual disorder with a pornography subtype, but reviewers determined that there was not yet enough evidence to include the diagnosis in the 2013 publication;¹ and

Whereas, AMA policy supports protecting youth from viewing pornography (H-60.934) and creating awareness about victims of child pornography and abuse (H-60.990), but the AMA has no policy pertaining to adult pornography use or potential misuse; therefore be it

RESOLVED, That our American Medical Association support research on problematic pornography use, including its physiological and environmental drivers, appropriate diagnostic criteria, effective treatment options, and relationships to erectile dysfunction and domestic violence. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.
Received: 09/24/18

References:

1. Doring, N. M. The internet's impact on sexuality: A critical review of 15 years of research. *Computers in Human Behavior*. 2009;25(5):1089-1101.
2. Bóthe, B., Tóth-Király, I., Zsila, Á., Griffiths, M. D., Demetrovics, Z., & Orosz, G. (2018). The development of the problematic pornography consumption scale (PPCS). *The Journal of Sex Research*. 2018;55(3):395-406.
3. Weir, K. (2014). Is pornography addictive? *American Psychological Association*. 2014: 45(4):46.
4. Voon, V., et al. Neural correlates of sexual cue reactivity in individuals with and without compulsive sexual behaviours. *Plos One*. 2014;9(7):e102419.
5. Gola, M., et al. Can pornography be addictive? An fMRI study of men seeking treatment for problematic pornography use. *Biorxiv*. 2017.
6. Foubert, J. D. (2017). The public health harms of pornography: The brain, erectile dysfunction, and sexual violence. *Dignity: A Journal on Sexual Exploitation and Violence*. 2(3). <http://digitalcommons.uri.edu/dignity/vol2/iss3/6> Published July 12, 2017. Accessed April 3, 2018.
7. Janet, H. S. When words are not enough: The search for the effect of pornography on abused women. *Violence Against Women*. 2004: 10(1), 56-72.
8. Romito, P., & Beltramini, L. Watching pornography: Gender differences, violence and victimization. an exploratory study in Italy. *Violence Against Women*. 2011: 17(10), 1313-1326.
9. Simmons, C. A., Lehmann, P., & Shannon Collier-Tenison. Linking male use of the sex industry to controlling behaviors in violent relationships: An exploratory analysis. *Violence Against Women*. 2008: 14(4):406-417.

RELEVANT AMA POLICY**Child Pornography H-60.990**

The AMA (1) encourages and promotes awareness of child pornography issues among physicians; (2) promotes physician awareness of the need for follow-up psychiatric treatment for all victims of child pornography; (3) encourages research on child abuse (including risk factors, psychological and behavioral impact, and treatment efficacy) and dissemination of the findings; and (4) wherever possible, encourages international cooperation among medical societies to be alert to and intervene in child pornography activities.

Citation: BOT Rep. Z, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934

Our AMA:

- (1) Recognizes the positive role of the Internet in providing health information to children and youth.
- (2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
- (3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.
- (4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.
- (5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.

Citation: BOT Rep. 10, I-06; Modified: CSAPH Rep. 01, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 909
(I-18)

Introduced by: Wisconsin

Subject: Use of Person-Centered Language

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, Communication is one of the foundational aspects of patient care that impacts patient satisfaction and builds rapport between a physician and patient;¹ and

Whereas, Person-first language is a style of communication in which the person is listed first followed by descriptive terms, such as a disease state (e.g. “a person with schizophrenia” rather than “a schizophrenic”), which avoids defining a person by his or her disease state and places the emphasis on the person rather than the disease or disability; and

Whereas, The use of person-first language may improve the doctor-patient relationship,² encourage a healthy relationship between researchers and the community,^{3,4} and may reduce stigma associated with certain disease states;^{5,6} and

Whereas, Multiple organizations including the federal Centers for Disease Control and Prevention, American Psychological Association, and American Society of Addiction Medicine encourage person-first language;^{7,8,9,10,11,12} and

Whereas, Person-centered language is a style of communication that incorporates an individual’s preference and identity when referring to a disease state (e.g. “a blind person” or “a person with blindness” based on personal preference), which may deviate from person-first language; and

Whereas, The use of person-centered language focuses on each person’s individual preferences rather than using generalizing terms for a group when referring to a disease state or disability, which seeks to maintain dignity and respect for all individuals;^{13,14} and

Whereas, Certain groups - such as the deaf and the blind communities - speak against using person-first language because they identify their disability as a trait they possess instead of a pathologic process, and this issue is mitigated by using person-centered language;^{15,16} and

Whereas, The Canadian Alzheimer's Society has developed specific guidelines for using person-centered language as to “not diminish the uniqueness and intrinsic value of each person and to allow a full range of thoughts, feeling and experiences to be communicated,” and to continue to build trusting relationships with these patients regardless of their condition;¹³ and

Whereas, The AMA recommends the use of person-first language in the AMA Code of Style, and recently adopted policy regarding the use of person-first language for obesity (H-440.821) but failed to include other disease states; therefore be it

- 1 RESOLVED, That our American Medical Association encourage the use of person-centered
2 language. (New HOD Policy)

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

Received: 09/25/18

RELEVANT AMA POLICY

Person-First Language for Obesity H-440.821

Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully.

Citation: Res. 402, A-17; Modified: Speakers Rep., I-17

References:

1. Mohammed, K *et al.* Creating a Patient-Centered Health Care Delivery System: A Systematic Review of Health Care Quality From the Patient Perspective. *Amer. J of Med.* 2016; 31(1): 12-21.
2. Schwartz, D *et al.* Seeing the Person, Not the Illness: Promoting Diabetes Medication Adherence Through Patient-Centered Collaboration. *Clin. Diabetes.* 2017 Jan; 35(1): 35-42.
3. Tai-Seale, M *et al.* The Language of Engagement: "Aha!" Moments from Engaging Patients and Community Partners in Two Pilot Projects of the Patient-Centered Outcomes Research Institute. *Perm J.* 2016 Spring; 20(2): 89-92.
4. Wynia M and Matiassek J. Promising Practices for Patient-Centered Communication with Vulnerable Populations: Examples from Eight Hospitals. *The Commonwealth Fund.* 2006.
5. Puhl R, Peterson JL, Luedicke J. Motivating or stigmatizing? Public perceptions of weight-related language used by health providers. *Int J Obes (Lond).* 2013 Apr; 37(4): 612-9.
6. Noble AJ *et al.* 'Epileptic', 'epileptic person' or 'person with epilepsy'? Bringing quantitative and qualitative evidence on the views of UK patients and carers to the terminology debate. *Epilepsy & Behavior* 2017 Feb; 67: 20-27.
7. National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention. Disability Inclusion Strategies. 1 August 2017. Available at <https://www.cdc.gov/ncbddd/disabilityandhealth/disability-strategies.html>, Accessed 6 September 2017.
8. Dunn, DS and Andrews, EE. Person-first and identity-first language: Developing psychologists' cultural competence using disability language. *American Psychologist* 2015; 70(3): 255-264.
9. Botticelli MP and Koh HK. Changing the Language of Addiction. *JAMA.* 2016; 316(13): 1361-1362.
10. Obesity Action Coalition. Person-First Language for Obesity. 2017. Available at <http://www.obesityaction.org/weight-bias-and-stigma/people-first-language-for-obesity>, Accessed 19 September 2017.
11. National Alliance on Mental Illness. How to Be Inclusive and Welcoming. 2017. Available at <https://www.nami.org/Get-Involved/NAMI-FaithNet/How-to-Be-Inclusive-and-Welcoming>, Accessed 19 September 2017.
12. Psychiatric Rehabilitation Association. PRA Language Guidelines. 2002. Available at <https://www.nccdp.org/resources/PRAlanguageguidelines.pdf>, Accessed 6 September 2017.
13. Canadian Alzheimer's Society. Person-Centered Language. December 2012. Available at http://www.alzheimer.ca/~media/Files/national/Culture-change/culture_person_centred_language_2012_e.pdf, Accessed 6 September 2017.
14. Kapitan, A. On "Person-First Language": It's Time To Actually Put The Person First. *RadicalCopyEditor.com.* 3 July 2017. Available at <https://radicalcopyeditor.com/2017/07/03/person-centered-language/>, Accessed 6 September 2017.
15. Collier, R. Person-first language: Noble intent but to what effect? *CMAJ.* 2012 Dec 11; 184(18): 1977-1978.
16. Mackelprang, R. Cultural Competence in Persons with Disabilities. In: Lum, Doman, Ed. *Culturally Competent Practice. A framework for understanding diverse groups and justice issues.* 4th ed. Belmont, CA: Brooks/Cole CENGAGE Learning; 2011: 437-465.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 910
(I-18)

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

Subject: Shade Structures in Public and Private Planning and Zoning Matters

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 Whereas, Malignant melanoma is now the fifth most common cancer in the United States, and
2 its incidence has increased 33-fold since 1935, with sun exposure being the principle cause;^{1, 2,}
3 ^{3, 4} and
4

5 Whereas, The Surgeon General's "Call to Action to Prevent Skin Cancer" of 2014⁵ concisely
6 outlined the magnitude of the public health problem which skin cancer represents in this
7 country, and recommended multiple strategies to decrease the risk of this preventable cancer,
8 including special attention to the provision of shade structures in the planning of public and
9 private spaces; and
10

11 Whereas, Shade structures are often treated as accessory buildings in planning and zoning
12 matters, and this can result in the denial of reasonable shade protection in public and private
13 spaces; therefore be it
14

15 RESOLVED, That our American Medical Association support sun shade structures (such as
16 awnings, gazebos and other structures providing shade) in the planning of public and private
17 spaces, as well as in zoning matters and variances in recognition of the critical importance of
18 sun protection as a public health measure. (New HOD Policy)

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

Received: 09/25/18

References

1. CA Cancer J Clin 2010; 60: 277-300
2. CA Cancer J Clin 2008; 58: 71-96
3. Skin Cancer Foundation Journal Vol 29; 65-67
4. CA Cancer J Clin 1998; 48: 232
5. *The Surgeon Generals Call to Action to Prevent Skin Cancer 2014*

Informational Reports

BOT Report(s)

- 02 Redefining AMA's Position on ACA and Healthcare Reform
- 03 2018 AMA Advocacy Efforts
- 06 Update on TruthinRx Grassroots Campaign
- 13 2019 Strategic Plan

CEJA Opinion(s)

- 01 Medical Tourism
- 02 Expanded Access to Investigational Therapies
- 03* Mergers of Secular and Religiously Affiliated Health Care Institutions - CORRECTED

CME Report(s)

- 02 Review of AMA Educational Offerings
- 07 50th Anniversary of the AMA Physicians' Recognition Award and Credit System
- 08 Study of Medical Student, Resident and Physician Suicide

Report of the Speakers

- 01 Recommendations for Policy Reconciliation

REPORT OF THE BOARD OF TRUSTEES

B of T Report 2-I-18

Subject: Redefining AMA's Position on ACA and Healthcare Reform

Presented by: Jack Resneck, Jr., MD, Chair

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform," which called on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on a number of specific issues related to the Affordable Care Act (ACA) and health care reform. The adopted policy went on to call for our AMA to report back at each meeting of the HOD. BOT Report 6-I-13, "Redefining AMA's Position on ACA and Healthcare Reform," accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

EFFORTS TO REPEAL THE ACA

Following the failure of Congress to repeal the Affordable Care Act, the Administration has continued to take steps to undermine the law or provide coverage options outside of the ACA exchanges which could have the impact of weakening the individual market. Previously, the Administration had decided to discontinue payment of cost-sharing reduction benefits to support required premium support for low income individuals enrolled in the ACA exchanges. Other recent actions have included:

- On June 7, 2018, the Department of Justice filed a brief declining to defend the ACA in a case (Texas v. United States) brought by 20 state attorneys general. A week later, our AMA and four physician specialty associations filed an Amicus Brief urging the court to reject the effort to undermine the ACA. In announcing the filing, the AMA noted that "if the lawsuit were successful, federal policy could roll back to 2009, which would be remarkably disruptive to our nation's health system and every single American." It would void protections for those with pre-existing conditions, and provisions that allow children to remain on their parents' plan until age 26. Insurers would no longer be held to the 85 percent medical loss ratio, meaning they could generate higher profits at the expense of coverage and payments for services, and 100 percent coverage for certain preventive services would cease. Furthermore, annual and lifetime dollar limits could be reinstated, leading to more bankruptcies due to health care costs.
- Following on an earlier Executive Order and proposed rulemaking, the Department of Labor on June 19 issued a final rule that would allow more small employers and individuals to form Association Health Plans (AHPs). The Congressional Budget Office has estimated that most individuals in AHPs will be healthier and have higher incomes than individuals in the ACA exchanges, potentially driving up premiums in the exchanges. In comments on the proposed rule, our AMA noted support for increasing health plan choices for individuals and small businesses seeking coverage in the individual and small group markets, but expressed concern that the plans outlined in the proposed rule fell short of maintaining crucial state and federal patient and provider protections and could result in substandard health coverage. Our AMA also expressed concern over the preemption of state insurance laws and the potential for insolvent and fraudulent AHPs. On July 26, attorneys general of 14 states challenged the rule

1 in the U.S. District Court for the District of Columbia alleging that changing the definition of
2 employer is inconsistent with the ACA and is a violation of the Administrative Procedures Act.

- 3 • The Centers for Medicare & Medicaid Services (CMS) announced on July 7, 2018, a delay of
4 ACA risk adjustments for 2017. As noted in a July 16 letter opposing the decision, the risk
5 adjustment program protects insurers from unanticipated costs in the event their enrollees are
6 less healthy by transferring funds from plans with healthier enrollees. It is the only ACA
7 premium stabilization program that is permanent. The letter was signed by our AMA and 27
8 other organizations representing physicians, hospitals, and patients. Members of both parties in
9 Congress also expressed concern with the decision. Late on July 24, CMS announced that the
10 program would be reinstated following changes to the methodology that had played a part in
11 the decision to suspend the program.
- 12 • On July 10, CMS announced a significant cut to funding for consumer enrollment assistance
13 and outreach through the navigator program. Funding for the 34 states with ACA federal
14 market places was cut to \$10 million, 80 percent less than just two years previous. Again, the
15 patient and provider community came together to protest this action. On July 26, 190
16 organizations, including the AMA, wrote HHS Secretary Alex Azar and CMS administrator
17 Seema Verma protesting the decision and urging the restoration of outreach funding.
- 18 • On August 1, the Administration gave the go ahead for short-term limited-duration plans of
19 364 days, with renewals allowed for up to 36 months. The plans would not be required to
20 comply with ACA protections such as coverage for pre-existing conditions or provide for
21 comprehensive benefits. In earlier comments urging withdrawal of the proposal, our AMA had
22 expressed support for the goal of increasing health plan choices but warned that the proposal
23 would undercut crucial state and federal patient protections, disrupt and destabilize the
24 individual market and result in substandard, inadequate health insurance coverage.

25 26 REPEAL AND APPROPRIATE REPLACEMENT OF THE SGR AND PAY-FOR- 27 PERFORMANCE 28

29 On July 12, CMS released a proposed rule for calendar year 2019 addressing both the Medicare
30 Physician Fee Schedule and the Quality Payment Program. In addition to the implementation of
31 Medicare Access and CHIP Reauthorization Act (MACRA) modifications enacted as part of the
32 Bipartisan Budget Act of 2018 (BBA18), discussed in a previous edition of this report, there are a
33 number of additional positive elements in the 2019 Proposed Rule. These include:

- 34
35 • Reduced documentation burden for Evaluation & Management (E&M) office visit codes,
36 though at this time, the degree of actual burden reduction is uncertain.
- 37 • New payments for physician services that are not part of a face-to-face visit (virtual check-ins
38 with patients, remote consults with patients using videos/photographs, online consults with
39 other physicians).
- 40 • Continuation of low volume threshold policy to exempt small practices from the Merit-based
41 Incentive Payment System (MIPS).
- 42 • A reduction in problematic measures in the Promoting Interoperability provisions (formerly
43 Meaningful Use and Advancing Care Information).

44
45 There are, however, areas of concern where the AMA will be recommending changes, including:

- 46
47 • E&M coding and related policies (add-on codes, multiple same day service reduction).
- 48 • AMA will urge reductions in quality measure requirements to reflect reductions in available
49 quality measures.
- 50 • Simplifying the MIPS scoring framework to make it more clinically relevant and
51 understandable for physicians.

- Keeping the cost category weight at 10 percent rather than increasing it to 15 percent.

The AMA is working closely with national, state and other physician groups to address widespread concerns with the proposed E&M coding changes. As part of our standard process to respond to major policy proposals our AMA is working with national specialty, state and other physician groups to develop recommendations that have broad support across the profession. A joint working group of CPT and RUC experts has been formed to develop recommendations for adjusting E&M coding policies. Given the complexity in this space, a coding change application may not be finalized until early November that may be voted on by the CPT Editorial Panel in early February. While the E&M coding issues have become a major focus, there are many important issues as part of the QPP or MACRA implementation that will have a significant impact on physician practices.

On July 24, 2018, AMA Immediate Past President David O. Barbe, MD, MHA, testified before the Health Subcommittee of the U.S. House of Representatives Committee on Energy and Commerce on the topic of “MACRA and MIPS: An Update on the Merit-based Incentive Payment System.” Dr. Barbe reminded the committee members that, despite challenges in implementing the MACRA reforms, they continue to be a significant improvement over the previous SGR update system and other legacy programs that were in place prior to MACRA. While the AMA has expressed support for recent improvements to MACRA, including those implemented as part of BBA18, we recognize the need for continued improvements to move further in the direction of choice, flexibility, simplicity and feasibility. These include further simplification and harmonization of the four separate components of MIPS. The AMA will continue to work with Congress and the Administration to refine the current system.

REPEAL AND REPLACE THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

The Bipartisan Budget Act of 2018 also repealed the IPAB which was to have been established under provisions of the ACA. Prior to its repeal, no appointments had ever been made to IPAB and the requirement for recommendations for Medicare cuts by the board was never triggered.

SUPPORT FOR MEDICAL SAVINGS ACCOUNTS, FLEXIBLE SPENDING ACCOUNTS, AND THE MEDICARE PATIENT EMPOWERMENT ACT

On July 11, 2018, the House Committee on Ways and Means reported 10 separate pieces of legislation to promote the use of consumer directed health care plans, including health savings accounts. After review, our AMA expressed support for eight of the proposals which were consistent with policies adopted by the House of Delegates.

On July 25, the full U.S. House of Representatives considered two bills which had been modified to substantially include the subject matter of nine of the bills previously considered by the Committee on Ways and Means.

H.R. 6199, the “Restoring Access to Medication and Modernizing Health Savings Accounts Act of 2018,” passed the House by a vote of 277-142. The underlying bill accomplished a long-supported AMA policy of restoring the ability of consumers to use HSAs, MSAs and HRAs to purchase over the counter drugs and expanded that policy to include feminine hygiene products as qualified expenses. Additionally, the bill adopted by the House allows those accounts to be used for the purchase of gym memberships and equipment, within certain limits; allows high-deductible plans to cover as much as \$250 of non-preventive care before the deductible is met; and allows individuals to keep eligibility for an HSA while maintaining a direct primary care service arrangement and, within limits, use HSA funds for those arrangements. The adopted bill also

1 excludes some items and services from being considered as other coverage if provided at an
2 employer-owned or retail clinic; allows transfer of funds from an FSA or HRA to an HSA under
3 certain circumstances; and allows individuals to maintain eligibility for an HSA if their spouse had
4 coverage under an FSA as long as the FSA is limited to expenses incurred by the spouse.

5
6 H.R. 6311, Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts
7 Act of 2018, passed the House by a vote of 242-176. The bill would delay for another two years the
8 Health Insurance Tax imposed by the ACA. It would also allow anyone to purchase a catastrophic
9 plan, as opposed to the current limitation to those under age 30 or with specific hardship
10 conditions. The bill increases allowed HSA contributions to match the maximum in allowed out-of-
11 pocket costs and would allow bronze and catastrophic plans offered through ACA exchanges to be
12 used with an HSA. H.R. 6311 also allows beneficiaries enrolled only in Medicare Part A to
13 contribute to an HSA and allows FSA balances to be carried over to subsequent years, though any
14 contribution limits for the next year would be lowered by the amount over \$500 that was carried
15 over.

16
17 At this writing, the potential for Senate consideration is not clear.

18 19 STEPS TO LOWER HEALTH CARE COSTS

20
21 Our AMA continues to engage with Congress and the Administration on a wide range of efforts
22 designed to lower health care costs. Ongoing efforts to address the cost of prescription drugs
23 remain among the highest profile of these efforts. On July 16, the AMA filed comments on the
24 Administration's "Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs." In the
25 comments, AMA noted that "patients are increasingly taking greater clinical risks when treatments
26 are cost prohibitive." AMA comments, which are available on the AMA website, addressed a wide
27 range of cost drivers, including issues related to competition, transparency, the Part B drug benefit
28 program, value-based pricing, and the 340B discount program.

29
30 During June and July, the Senate Committee on Health, Education, Labor and Pensions held a
31 series of hearings on reducing health care costs focusing on rural health cost drivers, administrative
32 costs, the role of quality and value in reducing excess spending. The AMA remains engaged in
33 conversation with the committee as well as in other Congressional efforts to address the impact of
34 administrative and regulatory costs and improve transparency of health care costs.

35 36 REPEAL NON-PHYSICIAN PROVIDER NON-DISCRIMINATION PROVISIONS OF THE ACA

37
38 Guidance released by the Department of Health and Human Services in 2014 included a positive
39 interpretation of health plan requirements under section 2706(a) of the ACA, specifically clarifying
40 that the section does not require "that a group health plan or health insurance issuer contract with
41 any provider willing to abide by the terms and conditions for participation." Nevertheless, the
42 AMA will continue to seek legislative opportunities to repeal this provision.

43 44 CONCLUSION

45
46 Our AMA will remain engaged in efforts to improve the health care system through policies
47 outlined in D-165.938 and other directives of the House of Delegates.

REPORT 3 OF THE BOARD OF TRUSTEES (I-18)
2018 AMA Advocacy Efforts

EXECUTIVE SUMMARY

Policy G-640.005, “AMA Advocacy Analysis,” calls on the Board of Trustees (BOT) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year’s advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The BOT has prepared this report to fulfill this HOD directive and to provide an update on 2018 American Medical Association (AMA) advocacy activities.

The AMA was a strong and effective advocate once again for our nation’s patients and physicians this year. The AMA advanced HOD-developed policy on numerous issues. Key victories for the AMA and the Federation of Medicine include:

- Convincing Anthem to reverse course on its Modifier 25 proposal which averted cuts of \$100 million in annual payments to physician practices;
- Legislative improvements to the Quality Payment Program (QPP) which will ease physicians’ QPP transition;
- Repeal of the Independent Payment Advisory Board (IPAB);
- Reauthorization of the Children’s Health Insurance Program (CHIP) for 10 years;
- Progress on key recommendations from the AMA Opioid Task Force regarding physician prescribing, physician education, use of prescription drug monitoring programs (PDMPs), and naloxone prescription availability;
- More than 60 state-level victories in collaboration with the Federation on key issues including opioids, insurer practices, and scope of practice;
- Release of the Economic Impact Statement report, which gives policymakers concrete evidence demonstrating how their local communities tangibly benefit when they support legislation that helps physician practices thrive; and
- Over 2 million grassroots engagements through social media to advance the AMA advocacy agenda.

Staff note: This report was prepared in September 2018, and may be updated prior to the Interim Meeting based on more recent advocacy developments.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 3-I-18

Subject: 2018 AMA Advocacy Efforts

Presented by: Jack Resneck, Jr., MD, Chair

1 BACKGROUND

2
3 Policy G-640.005, “AMA Advocacy Analysis,” calls on the Board of Trustees (BOT) to provide a
4 report to the House of Delegates (HOD) at each Interim Meeting highlighting the year’s advocacy
5 activities and should include efforts, successes, challenges, and recommendations/actions to further
6 optimize advocacy efforts. The BOT has prepared the following report to provide an update on
7 2018 American Medical Association (AMA) advocacy activities.

8
9 Once again in 2018, the AMA was a strong and effective advocate for our nation’s patients and
10 physicians. Key wins included Anthem’s reversal of its Modifier 25 policy, Quality Payment
11 Program (QPP) improvements, repeal of the Independent Payment Advisory Board (IPAB), and
12 extension of the Children’s Health Insurance Program for 10 years. The AMA also conducted
13 impactful research such as the Economic Impact Study report. AMPAC continued its strong
14 performance and positioned the AMA to be influential in the 2018 elections (see separate report in
15 Not for Official Business Bag). Finally, AMA grassroots networks and microsites were extremely
16 effective with over 2 million grassroots engagements to advance our advocacy agenda through
17 social media.

18 DISCUSSION OF 2018 ADVOCACY EFFORTS

19 *Health system reform*

20
21
22
23 In the Bipartisan Budget Act of 2018, Congress repealed the Independent Payment Advisory Board
24 (IPAB) which was an AMA priority and came after several years of strong Federation advocacy. In
25 the same bill, Congress extended the Children’s Health Insurance Program (CHIP) for 10 years.
26 Further, the AMA convinced Congress to strike the House-passed language that would have
27 extended the expiring “misvalued codes” provision for an additional year in 2019. Such a provision
28 would have had both short term and longer term negative effects for physicians.

29
30 On June 7, 2018, the Department of Justice filed a brief declining to defend the Affordable Care
31 Act (ACA) in a case (*Texas v. United States*) brought by 20 state attorneys general. A week later,
32 the AMA and four physician specialty associations filed an amicus brief urging the court to reject
33 the effort to undermine the patient care gains under the ACA. In announcing the filing, the AMA
34 noted that “if the lawsuit were successful, federal policy could roll back to 2009, which would be
35 remarkably disruptive to our nation’s health system and every single American.” It would void
36 protections for those with pre-existing conditions, and provisions that allow children to remain on
37 their parents’ plan until age 26. Insurers would no longer be held to the 85 percent medical loss
38 ratio, meaning they could generate higher profits at the expense of coverage and payments for
39 services, and 100 percent coverage for certain preventive services would cease. Furthermore,

1 annual and life-time dollar limits could be reinstated, leading to more bankruptcies due to health
2 care costs.

3
4 Also in 2018, the Administration and the Congress attempted to continue chipping away at the
5 infrastructure of the ACA. The major “repeal and replace” efforts from 2017 were not repeated, but
6 there were several efforts to modify the ACA’s impact. The AMA commented extensively in the
7 regulatory process on the Administration’s actions—cutting back funds for navigators, shortening
8 the enrollment period, eliminating the cost sharing reduction subsidies, expanding association
9 health plans and short-duration limited coverage plans, and reducing risk adjustment payments.
10 The AMA is concerned that these actions will lead to higher cost/lower quality health plan choices
11 for many patients. The AMA is also opposing Medicaid work requirements that are being
12 considered by both federal and state policymakers.

13
14 *QPP implementation*

15
16 The AMA continues to support physicians as they transition to the Quality Payment Program
17 (QPP). The AMA is also working to improve the QPP at both the regulatory and legislative levels.
18 The Bipartisan Budget Act of 2018 included a number of QPP refinements requested by the AMA:

- 19
20 • Medicare Part B drug costs will be excluded from the Merit-based Incentive Payment System
21 (MIPS) payment adjustments and from the low-volume threshold determination;
22 • The Centers for Medicare & Medicaid Services (CMS) may reweight the MIPS cost
23 performance category to not less than 10 percent for the third, fourth and fifth program years
24 (rather than requiring a weight of 30 percent in the third year);
25 • CMS has more flexibility in setting the MIPS performance threshold for years three through
26 five to ensure a gradual and incremental transition to the threshold being set at the mean or
27 median performance level in the sixth year; and
28 • The Physician Focused Payment Model Technical Advisory Committee may provide initial
29 feedback regarding the extent to which alternative payment model proposals meet criteria and
30 an explanation of the basis for the feedback.

31
32 On July 12, CMS released a proposed rule covering Medicare physician fee schedule and QPP
33 changes for 2019. Positive elements of the proposal included:

- 34
35 • Reduced documentation burden for evaluation and management (E/M) office visit services;
36 • New payments for services that are not part of a face-to-face visit (e.g., virtual check-ins with
37 patients, remote patient consults using videos/photographs, online consults with other
38 physicians);
39 • Continuation of the low volume threshold policy to exempt practices from MIPS; and
40 • A reduction in problematic measures in the Promoting Interoperability component of MIPS
41 (formerly Meaningful Use and Advancing Care Information).

42
43 However, there were also several areas of concern for which the AMA will be recommending
44 changes in its comments to CMS, which are due on September 10. These include:

- 45
46 • A proposed collapse of E/M payments for physician office visit codes;
47 • Reduced payments for office visits and procedures performed on the same day; and
48 • The need for a simplified MIPS scoring framework and reduced quality measure requirements.

49
50 The AMA has been working with Federation groups to further identify positive and problematic
51 aspects of the proposed regulations, as well as potential constructive solutions.

Regulatory relief

The AMA is focused on regulatory relief and administrative simplification issues beyond what is included in the QPP. For example, in 2017 the AMA convinced CMS to retroactively align legacy pay-for-reporting programs with the current MIPS program for the 2016 reporting period, reducing penalties for physicians by \$22 million in 2018. This year, major regulatory wins include:

- The Veterans Administration agreed to exempt only employed physicians from multistate licensure requirements when delivering telehealth services;
- CMS created a new beneficiary look-up tool and launched an education campaign to assist physicians as beneficiaries' social security numbers are removed from their Medicare cards;
- CMS delayed implementation of appropriate-use criteria;
- Office of the National Coordinator promoted AMA STEPS Forward™ modules with the Federal Health IT Playbook;
- Medicare administrative contractors now must use targeted modeling for audits that emphasizes education to prevent billing errors before they are referred to recovery audit contractors (RACs);
- CMS auditors must use predictive analytics to focus audits on claims that are at high risk for improper payments; and
- RAC auditors now must reimburse physicians for medical records as part of the audit process.

The AMA also sponsored an online discussion board with practice managers and two focus groups with physicians in Chattanooga, TN, and Iselin, NJ, to further explore physicians' regulatory burdens in order to refine and prioritize its advocacy agenda. Topics covered during the discussions included electronic health record requirements, prior authorization, carrier audits, documentation burdens, prescription drug monitoring programs, and patient translators, among others.

The AMA also commented both to Congress and the Administration on the impact that current Stark self-referral and the anti-kickback statutes are having on physician development and adoption of alternative payment models.

Further, the AMA, through the Professional Satisfaction and Practice Sustainability focus area, has created a Debunking Regulatory Myths website to clarify common regulatory compliance questions for physicians as part of the broader effort to reduce administrative burdens.

Prior authorization (PA)

Prior Authorization (PA) has grown into a major concern among physicians due to patient care delays and practice burdens. The AMA conducted a survey of 1,000 practicing physicians at the end of 2017 which was released this year. Among surveyed physicians, 64 percent reported waiting at least one day for PA decisions from health plans, while 30 percent reported waiting at least three business days. Not surprisingly, 92 percent of physicians said that PA can delay access to necessary care. These delays may have serious implications for patients, as 78 percent of physicians reported that PA can lead to treatment abandonment, and 92 percent indicated that PA can have a negative impact on patient clinical outcomes. Moreover, PA hassles have been growing over time, with 86 percent of physicians reporting that PA burdens have increased over the past five years. Physicians and practice managers also placed PA at the top of their list of administrative frustrations in focus groups and online research conducted by the AMA.

To address these issues, the AMA has undertaken a major campaign to urge health plans to "right-size" PA programs. In January 2017, the AMA established a coalition of 16 other organizations and

1 released a set of 21 Prior Authorization and Utilization Management Reform Principles. Over 100
2 additional provider and patient groups have signed on to the principles as formal supporters. The
3 principles spurred conversations with health plans about the need for significant reform in PA
4 programs. One result of these discussions was the January 2018 release of the Consensus Statement
5 on Improving the Prior Authorization Process by the AMA, American Hospital Association,
6 America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield
7 Association, and Medical Group Management Association. This document reflects an agreement
8 between provider and health plan organizations to pursue PA reform in several key areas.

9
10 State legislative efforts are also critical in the AMA's campaign to improve PA processes, and the
11 AMA is working with state and specialty societies to enact PA and utilization management
12 legislation. The AMA offers model legislation that continues to serve as the basis for many of the
13 state bills and provides resources and support for these efforts. This year alone, more than 20 states
14 are addressing utilization management reform in their legislatures with significant enactments in
15 Indiana, New Mexico, and West Virginia. Physicians struggle with PA in the Medicare Advantage
16 (MA) and Medicare Part D drug plans, so the AMA is addressing PA issues at the federal level too.
17 These efforts include a recent AMA letter to CMS disputing the findings of a Government
18 Accountability Office report that recommended increased use of PA for Medicare-covered services.

19
20 The AMA has also launched a grassroots advocacy website dedicated to PA
21 (www.FixPriorAuth.org). The website includes both patient- and physician-oriented online
22 experiences that end with a "share your story" call to action. Compelling stories gathered thus far
23 are featured in the site's story gallery, and additional physician and patient PA accounts will be
24 added over time and used to guide and support the AMA's advocacy efforts. FixPriorAuth.org also
25 contains a resource library of PA-related news stories and AMA PA advocacy and educational
26 tools, including the three-part video series on electronic prior authorization that has been approved
27 for 0.25 credits of *AMA PRA Category 1 Credit*™.

28 29 *Telemedicine*

30
31 After concerted AMA advocacy coupled with the efforts of the Digital Medicine Payment
32 Advisory Group (DMPAG), beginning January 1, 2018, Medicare expanded coverage of remote
33 patient chronic care management. This represents a historic expansion of coverage that extends
34 throughout the country without geographic limitations and includes services delivered virtually in a
35 patient's home. In addition, CMS has proposed to cover additional remote patient management
36 services including a range of technical and professional components that accurately reflect the costs
37 of delivering such services beginning January 1, 2019. Furthermore, the AMA's coalition building
38 and strong support for the Medicare telehealth provisions of the Bipartisan Budget Act of 2018
39 which passed earlier this year paves the way for expanded Medicare coverage for telestroke and
40 telehealth services for patients with end stage renal disease, chronically ill patients in Medicare
41 Advantage, as well as coverage of telehealth for beneficiaries in certain accountable care
42 organizations (two-sided risk models only).

43
44 The AMA has also worked at the state level to ensure coverage of telemedicine and modernization
45 of medical practice acts. In the 2018 legislative session, 44 states introduced over 160 telehealth-
46 related pieces of legislation. Many bills addressed different aspects of payment regarding both
47 private payers and Medicaid, with some bills making changes to existing payment laws. Many
48 states also proposed legislation directing licensure boards to establish standards for the practice of
49 telehealth within their given profession. The AMA was pleased to see that many of these bills were
50 either based on the AMA Telemedicine Act, or were amended to incorporate language from this
51 model bill. In addition, the AMA supported several state efforts to join the Interstate Medical

Licensure Compact, with now 24 states, DC, and Guam participating in the Compact's expedited licensure process.

Diabetes Prevention Program (DPP)

CMS approved coverage of the Medicare Diabetes Prevention Program (MDPP) effective April 2018. This was a very positive development in the effort to prevent diabetes on a national scale. To further advance these efforts, the AMA has been urging CMS to approve coverage of virtual or digital MDPP programs participation to improve access in rural and underserved areas. The AMA also has ongoing discussions with staff at the Center for Medicare & Medicaid Innovation (CMMI) about the MDPP and has been working to disseminate information about it to potential suppliers. For example, the AMA convened a webinar for health systems interested in the DPP with a CMMI presenter and developed a question-and-answer document for them following the webinar.

Mergers

The AMA was instrumental in last year's action to block the Anthem/Cigna and Aetna/Humana mergers. The Anthem/Cigna merger alone would have cost physicians \$500 million in payments annually. In 2018, the AMA had to evaluate several new potential mergers that were not just a health insurer merging with a health insurer but more complicated mergers such as CVS/Aetna which involves a health insurer merging with a pharmacy chain/pharmacy benefits manager (PBM).

In February, the AMA submitted a statement to the House Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law for a hearing on this merger. The statement expressed the AMA's concerns that the proposed merger has the potential to worsen competition (or reduce hopes for amelioration) in three poorly performing markets: PBM services; local health insurance markets; and many local retail pharmacy markets.

On June 19, the AMA moved to oppose the CVS/Aetna merger. This was announced in California at a Department of Insurance (DOI) hearing. AMA President Barbara L. McAneny, MD, presented testimony urging regulators to block the proposed CVS/Aetna merger because it is likely to substantially lessen competition in many health care markets, to the detriment of patients. A CVS/Aetna deal would allow the combined corporate entity to fortify dominant positions in health insurance, pharmaceutical benefit management, retail and specialty markets that already lack competition. The AMA's filing for the hearing also outlined further the merger's potential negative consequences for health care access, quality and affordability, including:

- An expected increase in premiums due to a substantial increase in market concentration in 30 of 34 Medicare Part D regional markets;
- An anticipated increase in drug spending and out-of-pocket costs for patients as Aetna and CVS fortify their dominant positions in the health insurance, pharmaceutical benefit management, retail and specialty pharmacy markets that already lack competition;
- Reduced competition in health insurance markets that will adversely affect patients with higher premiums and contribute to a decline in the quality of insurance; and
- A foreseeable failure to realize proposed efficiencies and benefits because the merger faces enormous implementation challenges, and those efficiencies have a questionable evidence base.

On August 1, 2018, the California DOI agreed with our arguments and those of the experts that testified, urging the U.S. Department of Justice (DOJ) to block the proposed merger. The AMA

1 also submitted extensive comments to the DOJ on the proposed merger on August 8. At the time of
2 this report, the outcome of the proposed merger had yet to be decided, so AMA advocacy
3 continues.

4 5 *Insurer coverage issues*

6
7 In 2018, the AMA continued to collaborate with state and specialty medical societies to ensure that
8 patients have appropriate coverage for unanticipated out-of-network care. The AMA continues to
9 promote coverage policies that are based on reasonable physician charges, to financially protect
10 patients and promote fair contracting between physicians and insurers. AMA model legislation
11 serves as the basis for many of these proactive efforts. Similarly, problematic state bills have been
12 regularly defeated as the AMA and medical societies communicate to legislators about their impact
13 on patient access to care and physician practice stability. The AMA has worked closely with state
14 medical associations and the American College of Emergency Physicians (ACEP) to combat
15 Anthem/BCBS policies that deny coverage for emergency care when the final diagnosis is
16 determined to be non-emergent. Legislative restrictions were adopted in Missouri.

17 18 *Modifier 25*

19
20 At the 2017 Interim Meeting, the House of Delegates established new policy to advocate against
21 payment reductions for evaluation and management (E/M) codes appropriately reported with a
22 Current Procedural Terminology (CPT) modifier 25. Considerable concerns regarding this issue
23 have been raised by many state medical associations and national medical specialty societies, most
24 recently in regard to health insurer Anthem's proposed policy to reduce payments by 50 percent for
25 E/M services billed with CPT modifier 25 when reported with a minor surgical procedure code
26 beginning in the first quarter of 2018. Several other insurers have followed suit with similar
27 proposals.

28
29 Starting in November 2017, the AMA advocated directly to Anthem to halt this proposed move.
30 The AMA sent a letter to Anthem expressing our concerns and hosted two meetings with AMA and
31 Anthem senior leadership. During these discussions, the AMA voiced strong objections to this
32 unwarranted reduction in physician payment and presented evidence showing that the
33 recommendations of the AMA/Specialty Society Relative Value Scale Update Committee (RUC)
34 do not include duplicative physician work or practice expense for procedures typically billed with
35 an E/M service on the same date. Many state medical associations and national medical specialty
36 societies also strongly advocated for Anthem to rescind this policy, which would impede the
37 provision of unscheduled, medically necessary care. Following these combined efforts, Anthem
38 withdrew its modifier 25 payment reduction. The AMA welcomed this news, as this policy would
39 have had resulted in a \$100 million cut in physician payments nationwide.

40
41 The AMA has continued advocacy on this issue, to include provision of supporting documentation
42 to assist medical societies in successfully fighting implementation of modifier 25 payment
43 reductions by Blue Cross Blue Shield of Michigan and Health Net in California. This will be an
44 ongoing campaign, and the AMA will engage national commercial insurers and governmental
45 entities considering similar policies involving modifier 25 or other CPT modifiers. The Centers for
46 Medicaid & Medicare Services proposed a new application of the Modifier 25 policy as part of the
47 Evaluation and Management coding proposals. In comments on the proposed rule, the AMA
48 stressed that these reductions were inappropriate and if advanced would necessitate an extensive
49 review of related codes to assure that services were accurately valued.

Opioid epidemic

The opioid epidemic continues to have a devastating effect on our nation; however, there are signs of progress in physicians' actions to help end this public health epidemic. The AMA Opioid Task Force issued a report in June 2018 highlighting some of this progress:

- Between 2013 and 2017, the number of opioid prescriptions decreased by more than 55 million—or 22.2 percent;
- Use of prescription drug monitoring programs (PDMPs) is growing—more than 300 million queries were made in 2017;
- Naloxone prescriptions more than doubled in 2017, from approximately 3,500 to 8,000 dispensed per week;
- More than 549,000 physicians and other health care professionals completed continuing medical education (CME) trainings and other Federation education resources in 2017; and
- Finally, the number of physicians trained/certified to provide buprenorphine in-office continues to rise—more than 50,000 physicians are now certified—a 42 percent increase in the past 12 months.

Attention to the need for increased access to Medication Assisted Therapy (MAT) resources is a top priority in 2018—as is calling on health insurers to eliminate PA requirements and other barriers to MAT as well as enhancing access to comprehensive, multidisciplinary treatments for pain, including non-opioid alternatives. AMA model state legislation can help address these and other related areas.

At the federal level, Congress enacted the Consolidated Appropriations Act of 2018 which includes nearly \$4 billion for prevention, treatment, and law enforcement efforts targeted at addressing the opioid epidemic. The AMA has been calling for increased federal funding for several years.

In 2018, the AMA offered background, analysis, and technical support to at least 25 states as they addressed the opioid epidemic. This includes support for bills aligned with AMA policy, and efforts to amend or defeat bills with negative provisions. The AMA also continues to maintain and update the AMA opioid microsite, www.end-opioid-epidemic.org, with more than 400 education and training resources specific to state and specialty societies.

Pharmaceutical cost transparency

In 2018, the AMA is encouraging patients and physicians to share their stories about the impact of drug pricing and is urging state medical associations to advance AMA model legislation to increase transparency requirements on payers, pharmacy benefit managers and pharmaceutical manufacturers. The AMA also updated the Truthinrx.org website and continues to issue regular updates through the Patients Action Network (PAN) and the Physicians Grassroots Network (PGN) social media channels. The campaign is well-positioned to engage grassroots pressure in favor of positive reform-minded legislation once it materializes.

In May of 2018, the Trump Administration issued a Blueprint for addressing the problem, which is a high priority for the Secretary of HHS, Alex Azar. While the Blueprint lacks detail on key issues, it appears the focus will be on limited regulatory actions that the Administration can take without action by Congress.

The AMA commented on the Blueprint, and expressed strong support for a select number of provisions: (1) requiring pharmaceutical supply chain transparency; (2) accelerating and expanding

1 regulatory action to increase pharmaceutical market competition and combat anti-competitive
2 practices; (3) ensuring prescribers have accurate point-of-care coverage and patient cost-sharing
3 information as part of their workflow, including in the electronic health record (EHR); and
4 (4) ensuring federal programs and commercial practices billed as lowering prescription medication
5 prices do so for patients directly. The AMA identified and expressed concern about Blueprint
6 proposals that would increase patient costs and erect barriers, including onerous insurer paperwork
7 requirements that impede timely patient access to affordable and medically necessary medications
8 and treatments. Further, the AMA opposes policies that would financially penalize physicians and
9 pharmacists for high cost prescription medication.

10
11 The AMA also sent a letter of support to the Hill for S. 2554, which would prohibit the use of gag
12 clauses in a manner the AMA strongly supports and would provide the Federal Trade Commission
13 with clear authority to combat pay for delay agreements entered into between biological/biosimilar
14 companies.

15
16 The AMA has also been working to influence legislative efforts at the state level to address drug
17 costs, often by questioning the business practices and value equation that pharmacy benefit
18 managers (PBMs) add to the system. The AMA has been engaged in the development of model
19 bills by both the National Association of Insurance Commissioners (NAIC) and the National
20 Conference of Insurance Legislators (NCOIL) to better regulate PBM practices. Additionally,
21 nearly 20 states have now enacted legislation to allow pharmacists to discuss drug costs and
22 payment options with patients (gag clause legislation)—policies supported by the AMA and
23 outlined in AMA model legislation.

24 25 *Gun violence*

26
27 After another series of tragic mass shootings, the AMA renewed the call for the U.S. Centers for
28 Disease Control and Prevention (CDC) to investigate the root causes of gun violence. There is
29 concern that the CDC is prohibited from conducting this research, but the Dickey Amendment only
30 prohibits the CDC from using appropriated funds “to advocate or promote gun control.” The AMA
31 urged Congress to earmark appropriations specifically for gun violence research efforts. It also
32 commented on proposed regulations issued by the Department of Justice on so-called “bump
33 stocks.”

34
35 As the push for federal funding continues, the AMA recently partnered with the American
36 Foundation for Firearm Injury Reduction in Medicine (AFFIRM), a physician-led, non-profit
37 organization that aims to counter the lack of federal funding for gun violence research by
38 sponsoring gun violence research with privately-raised funds. AMA Trustee, Albert Osbahr, III,
39 MD, is on AFFIRM’s steering committee; other physician group partners include the American
40 College of Surgeons, American College of Emergency Physicians, and the Massachusetts Medical
41 Society. More information about the group can be found at www.affirmresearch.org.

42
43 In 2018, nine states (Kansas, Louisiana, Maryland, New York, Ohio, Oregon, Utah, Vermont and
44 Washington) enacted laws restricting access to firearms for individuals convicted of domestic
45 violence or subject to a restraining order due to domestic violence. Delaware, Florida, Illinois,
46 Maryland, Massachusetts, New Jersey, Rhode Island and Vermont passed laws establishing gun
47 violence restraining orders. Nine states (Connecticut, Delaware, Florida, Hawaii, Maryland, New
48 Jersey, Rhode Island, Vermont, and Washington) banned bump stocks. Finally, Florida, Louisiana,
49 New Jersey, Oregon, Tennessee and Vermont strengthened background check requirements.

The AMA adopted several policies on gun violence at its 2018 Annual Meeting and will continue to seek opportunities at the federal and state levels to advance new and existing AMA policy on this topic:

- Advocating for schools as gun-free zones;
- Calling for a ban on the sale of assault-type weapons, high-capacity magazines;
- Expanding domestic violence restraining orders to include dating partners;
- Removing firearms from high-risk individuals;
- Supporting an increase in legal age of purchasing ammunition and firearms from 18 to 21;
- Opposing federal legislation permitting “concealed carry reciprocity” across state lines; and
- Supporting gun buyback programs in order to reduce the number of circulating, unwanted firearms.

Scope of Practice

Policy adopted at the 2017 Interim Meeting called on the AMA to convene a meeting of relevant physician stakeholders to create a consistent national strategy to effectively oppose efforts to grant independent practice to non-physician practitioners. To implement this directive, the AMA hosted a summit at AMA headquarters in March 2018. The Scope of Practice Partnership (SOPP) provided funding to support the summit. Eighty-one physicians, executive staff, and government affairs staff from 32 state medical associations, 16 national medical specialty societies, and the American Osteopathic Association joined AMA leadership and staff at the summit. The strategy resulting from this meeting was discussed in detail at the A-18 SOPP meeting and will guide our ongoing advocacy efforts.

In 2018, there was a great deal of concern about the Advanced Practice Registered Nurse (APRN) Compact, a multistate licensure compact developed by the National Council of State Boards of Nursing (NCSBN). It establishes a process by which an APRN with certain credentials can receive a multistate license that allows the APRN to practice in any APRN Compact member state. APRNs practicing under this multistate license can practice and prescribe independently, despite any state law to the contrary. Idaho, North Dakota, and Wyoming have joined the APRN Compact, which will go into effect if 10 states join. Due to AMA and Federation efforts, bills were defeated in Iowa, Minnesota, Nebraska, and no further APRN Compact bills were enacted in 2018.

Immigration

Based on policy adopted at A-18, the AMA wrote to the Administration to withdraw its “zero tolerance” immigration policy and to stop separating children from their families. The fear is that Administration’s policy will do great harm to children and their parents or caregivers. The AMA sent the letter to the secretaries of the Homeland Security and Health and Human Services departments, as well as the U.S. Attorney General. The letter pointed out that childhood trauma and adverse childhood experiences created by inhumane treatment often create negative health impacts that can last an individual’s entire lifespan. The president subsequently issued an executive order reversing the Administration’s position on separating children. The AMA is closely monitoring the reunification of parents and children.

The AMA also voiced concerns in a letter to the Director of the U.S. Citizenship and Immigration Services about delays in H-1B visa processing due to increased inspection of prevailing wage data for incoming non-U.S. international medical graduates (IMGs) who have accepted positions in U.S. Graduate Medical Education (GME) programs.

Cybersecurity

The AMA has been raising awareness of cybersecurity threats to physician practices. Last year, an AMA/Accenture survey of 1300 physicians found that phishing and viruses are the most common types of cyberattacks encountered by small practices. Viruses often appear as a result of software that is not regularly updated or “patched.” To assist physicians, the HHS Office for Civil Rights (OCR) issued a monthly newsletter devoted to cybersecurity issues. In addition to encouraging the federal government to issue additional guidance like this to physicians, the AMA continues to urge stakeholders—including health information technology vendors—to pay special attention to the needs of small and mid-sized practices, which often lack the resources that larger practices and health systems enjoy.

Protecting the patient-physician relationship

In response to the Administration’s plan to withhold federal family planning funding from Planned Parenthood and other entities, the AMA issued a statement and submitted comments strongly objecting to the policy change, asserting that it interferes with patient-physician relationships and negatively affects quality of care. The HHS announcement specifically noted that the regulation update “would prohibit referral for abortion as a method of family planning.” The proposal would also endanger access to care that the Title X program has helped to facilitate. Title X has helped to expand access to basic reproductive health care like birth control, cancer screenings, STI testing and treatment, and exams. The program serves roughly 4 million people every year, many of whom would otherwise be unable to access care. The AMA’s stance on this issue is in keeping with its longstanding position on maintaining patient choice and physician freedom to practice in the setting they choose, and reflects a broader commitment to protecting free communication between patients and physicians.

Physician conscience rights

In 2018, HHS issued a Notice of Proposed Rulemaking on “Protecting Statutory Conscience Rights in Health Care; Delegations of Authority.” In response, the AMA sent a letter to Secretary Azar to express opposition to the measure, citing concern for vulnerable patient populations and asserting that conscience rights for physicians are not unlimited. The proposed rule would dramatically expand the discretion that religious or moral objectors have to refuse care without meaningful safeguards to ensure that the rights of those receiving care are protected. The rule is part of a broader Administration effort to protect religious rights and follows the announcement in late January of the creation of a new office within the Office of Civil Rights (OCR), the Conscience and Religious Freedom Division. The AMA is alarmed because if implemented, the rule would function as a shield for people asserting objections on religious or moral grounds and could permit them to withhold care from already vulnerable groups and create confusion in health care institutions. While the AMA is committed to conscience protections for physicians and other health professional personnel, the exercise of those rights must be balanced against the fundamental obligations of the medical profession and physicians’ paramount responsibility and commitment to serving the needs of their patients.

Equality issues

Five states (Delaware, Hawaii, Maryland, New Hampshire, and Washington) enacted laws opposing “conversion therapy.” AMA policy strongly opposes conversion therapy, and the AMA stands ready to work with state medical associations interested in pursuing a ban on this harmful practice.

1 In addition, the AMA advocated before the U.S. Department of Veterans Affairs and the
2 Department of Defense on coverage for transgender-related health care services.

3
4 *Tobacco*

5
6 The AMA along with more than a dozen other physician groups sent a letter to ranking members of
7 the Senate and House appropriations committees urging them to oppose any provisions that weaken
8 or delay the U.S. Food and Drug Administration's (FDA) ability to regulate any and all tobacco
9 products. Responding to provisions passed by the House in recent years that exempt thousands of
10 tobacco products—including many candy- and fruit-flavored products now favored by teens—from
11 the scientific review process mandated by the Family Smoking and Prevention Tobacco Control
12 Act is cause for concern as 11.3 percent of high school students in 2016 reported using e-cigarettes
13 during the last 30 days. Under these House provisions, many tobacco products that the FDA had
14 only just begun to regulate, such as e-cigarettes and cigars, would be exempted from a product
15 review if they were on the market prior to Aug. 8, 2016. The oft-cited reason for these provisions is
16 the ability of e-cigarettes to help smokers quit traditional cigarettes; however, the efficacy of this is
17 not yet proven by the research.

18
19 At the state level, Maine and Oregon raised the tobacco purchase age to 21. Five states now have
20 this requirement. California, Hawaii, and New Jersey enacted laws in previous sessions.

21
22 *Economic Impact Study*

23
24 At the beginning of 2018, the AMA released its updated Economic Impact Study. The report gives
25 policymakers concrete evidence demonstrating how their local communities tangibly benefit when
26 they support legislation that helps physician practices thrive. The 2018 study found that nationally:

- 27
28 • Physicians support nearly 12.6 million jobs. On average, each physician supports more than 17
29 jobs;
30 • Physicians create a total of \$2.3 trillion in economic output, comprising about 13 percent of the
31 total U.S. economy. On average, each physician supports \$3.2 million in economic output;
32 • Physicians contribute more than \$1 trillion in wages and benefits for all supported jobs. On
33 average, physicians support \$1.4 million in total wages and benefits per physician; and
34 • Physicians support \$92.9 billion in state and local tax revenues—approximately \$126 thousand
35 per physician on average.

36
37 *AMPAC Activities*

38
39 AMPAC has once again worked closely with its state medical association PAC partners this
40 election cycle on contribution support decisions for candidates running Congress. A report
41 summarizing AMPAC activities will be distributed at the Interim Meeting in National Harbor.

42
43 **CONCLUSION**

44
45 Once again, the AMA has delivered some significant advocacy victories in a challenging political
46 environment. The outcome of the 2018 elections is unknown at the time this report was prepared,
47 but the AMA is poised to work with both sides of the aisle in 2019 to advance the interests of
48 patients and physicians on the most critical health care issues. The AMA thanks its Federation
49 partners for their collaboration and support and looks forward to tackling medicine's biggest issues
50 when newly elected state and federal officials take office in January.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 6-I-18

Subject: Update on TruthinRx Grassroots Campaign

Presented by: Jack Resneck, Jr., MD, Chair

1 INTRODUCTION

2
3 At the 2017 Interim Meeting, the House of Delegates adopted Policy D-110.988[2] “Prescription
4 Drug Price and Cost Transparency,” which asked for a report back to the House of Delegates at the
5 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign. This
6 report, which is presented for the information of the House, summarizes the creation of the
7 TruthinRx grassroots campaign, its evolution, and its progress and impact. The report also
8 summarizes relevant American Medical Association (AMA) policy and advocacy, which is
9 reflected in the TruthinRx grassroots campaign.

11 BACKGROUND

12
13 In 2015, Policy H-110.987, “Pharmaceutical Costs,” directed the AMA to convene a task force of
14 appropriate AMA Councils, state medical societies, and national medical specialty societies to
15 develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical
16 costs and improving patient access and adherence to medically necessary prescription drug
17 regimens. Accordingly, the AMA convened a Task Force on Pharmaceutical Costs, which met four
18 times in the first six months of 2016 to develop principles to guide advocacy and grassroots efforts
19 aimed at addressing pharmaceutical costs. The Task Force agreed that increasing transparency
20 among pharmaceutical companies, health plans, and pharmacy benefit managers (PBMs) should be
21 the initial focus of the campaign, which led to the launch of a grassroots campaign in the third
22 quarter of 2016, and the launch of the TruthinRx website, *TruthinRx.org*, on November 1, 2016.

24 EVOLUTION OF THE TRUTHINRX GRASSROOTS CAMPAIGN

25
26 The goal of the TruthinRx campaign has been to mobilize the AMA Physician Grassroots Network
27 (PGN), the AMA Patient Action Network (PAN), the public, and thought leaders around the
28 challenges posed by the lack of transparency surrounding prescription drug pricing and costs.
29 *TruthinRx.org* engages physicians, patients/consumers, and health care policy influencers by:
30 (a) providing critical information about prescription drug price and cost challenges, as well as the
31 lack of drug price and cost transparency, and (b) facilitating grassroots action in support of
32 improving prescription drug price and cost transparency. Since its launch in November 2016,
33 *TruthinRx.org* has evolved through two key stages. In its first stage, the *TruthinRx.org* landing
34 page focused on informing visitors about how drug price negotiations happen behind closed doors
35 and how pharmaceutical companies, PBMs, and health insurance companies participate in these
36 negotiations. The page concludes that “when patients are left out, health care suffers.” This landing
37 page directs visitors to four main website subsections:

- 38
39 • “Your Stories” – invites visitors to read and contribute their own stories about how the lack of
40 transparency in drug pricing impacts our health care system.

- 1 • “Behind the Label” – illustrates how the lack of transparency in prescription drug pricing and
- 2 costs – involving opaque price agreements between PBMs, health plans, and pharmaceutical
- 3 manufacturers – contributes to adverse patient effects such as increased costs and unpredictable
- 4 price swings for patients, and ultimately adversely affects patients and physicians.
- 5 • “Get Involved” – facilitates grassroots advocacy by providing visitors with a customizable
- 6 message that can be personalized to US Senators and Representatives, calling on legislators to
- 7 support increased transparency in prescription drug prices. Additionally, visitors have an
- 8 opportunity to subscribe to future legislative updates and alerts from the AMA.
- 9 • “Get Informed” – provides visitors with a myriad of timely articles to help them understand the
- 10 seemingly arbitrary costs of prescription medication. The articles are categorized according to
- 11 the following thought-provoking questions:
- 12 ○ “What influences the price of drugs?”
- 13 ○ “How does drug pricing affect patients like you?”
- 14 ○ “What’s being done to help?”

15
16 At the time that this report was written, the second stage of *TruthinRx.org* was scheduled to be
17 launched in fall of 2018 to further mobilize voters around the issue of prescription drug price
18 transparency. *TruthinRx.org* will include an interactive data visualization that highlights various
19 reasons why drug prices fluctuate. The data visualization will explore the roles of four key themes
20 behind drug price fluctuation: (1) generics – despite the assumption that generic drugs will be
21 affordable, over time, the prices of generic drugs can rise significantly; (2) competition – despite
22 the expectation that competition in the marketplace would lead to lower prices, competitors’ prices
23 can seemingly increase simultaneously; (3) acquisition – the price of drugs produced by a given
24 company can rise significantly after the company is acquired; and (4) supply chain dynamics –
25 PBMs cast themselves as saving money, but with the lack of supply chain transparency, it is
26 unclear how these middlemen negotiate drug prices. The data visualization will lead to a call to
27 action for improved transparency. This interactive subsection of *TruthinRx.org* can be used both on
28 mobile and desktop devices, and is designed so that it can be shared on social media.

29 30 PROGRESS AND IMPACT OF THE TRUTHINRX GRASSROOTS CAMPAIGN

31
32 The TruthinRx grassroots campaign has significantly impacted public awareness of, and grassroots
33 action in response to, the opaque process that pharmaceutical companies, PBMs, and health plans
34 engage in when pricing prescription drugs. Between the website’s launch in November 2016 and
35 August 2018, the TruthinRx campaign has achieved the following milestones:

- 36
37 • The TruthinRx campaign generated 827,759 messages sent to Congress demanding price
- 38 transparency.
- 39 • As part of the TruthinRx grassroots campaign, the PAN launched a petition calling for
- 40 increased prescription drug price and cost transparency, and this petition has been signed by
- 41 275,590 individuals.
- 42 • *TruthinRx.org* has been visited 117,474 times, by 95,873 unique internet users.
- 43 • The AMA has published 656 posts on Twitter and Facebook focused on the TruthinRx
- 44 campaign. Combined, these posts were displayed 10,859,853 times (“impressions”). This led to
- 45 514,118 people interacting with the posts (“engagements”).
- 46 • Evidencing the TruthinRx campaign’s continued impact on public discussion, since July 2017,
- 47 the hashtag “#TruthinRx” has been mentioned on Twitter and/or Facebook 1,617 times.

1 AMA POLICY AND ACTIVITY

2
3 It is important to recognize that the TruthinRx grassroots campaign is one key component of a
4 much broader, ongoing AMA focus on prescription drug affordability. Recent AMA policy and
5 activity aimed at improving prescription drug price and cost transparency include:

- 6
7 • The AMA developed and disseminated model state legislation entitled, “An Act to Increase
8 Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases during the
9 Plan Year.”
- 10 • The AMA submitted comments in July 2018 in response to the HHS Blueprint to Lower Drug
11 Prices and Reduce Out-of-Pocket Costs. Patient and other stakeholder experiences with
12 affordability and lack of access that were obtained through the TruthinRx campaign were
13 incorporated as vignettes in this comment letter. The AMA has received positive feedback on
14 these vignettes.
- 15 • In April 2018, Jack Resneck, Jr., MD, testified at the US House of Representatives Democratic
16 Steering and Policy Committee Briefing on Prescription Medication Pricing and Access
17 Challenges and Solutions. Dr. Resneck’s testimony focused on how the lack of prescription
18 drug pricing transparency impacts his patients.
- 19 • In December 2017, Gerald e. Harmon, MD, testified before the Health Subcommittee of the US
20 House of Representatives Committee on Energy and Commerce on the topic of “Examining the
21 Pharmaceutical Supply Chain.” Dr. Harmon’s testimony focused on what the escalating cost
22 and complexity of obtaining medically necessary prescriptions or physician-administered drug
23 treatments mean for patient adherence, timely access, and health outcomes.
- 24 • Policy H-110.987, which encourages prescription drug price and cost transparency among
25 pharmaceutical companies, PBMs, and health insurance companies and establishes extensive
26 AMA policy aimed at improving access to affordable prescription drugs, including: promoting
27 legislation that authorizes the Attorney General and/or the Federal Trade Commission (FTC) to
28 take legal action to address price gouging by pharmaceutical manufacturers and increase access
29 to affordable drugs for patients, and encouraging FTC actions to limit anticompetitive behavior
30 by pharmaceutical companies attempting to reduce competition from generic manufacturers.
- 31 • Policy H-110.987, also directs the AMA to provide assistance upon request to state medical
32 associations in support of state legislative and regulatory efforts addressing drug price and cost
33 transparency.
- 34 • Policy H-125.979, which supports legislation or regulation that secures private health insurance
35 formulary transparency.
- 36 • Policy H-110.991, which advocates for greater prescription drug price transparency at the
37 pharmacy point-of-sale.
- 38 • Policy H-110.991, also supports physician education regarding drug price and cost
39 transparency and challenges patients may encounter at the pharmacy point-of-sale.

40
41 Moreover, the AMA is continuing to develop evolving policy in support of improved prescription
42 drug affordability. Ongoing AMA initiatives include:

- 43
44 • At this Interim Meeting, the Council on Medical Service is presenting Report 1-I-18 that
45 addresses prescription drug importation for personal use.
- 46 • At the 2019 Annual Meeting, the Council on Medical Service will present a report that
47 addresses the impact of PBMs on patients.
- 48 • At the 2019 Annual Meeting, the Board of Trustees will present a report that addresses three
49 related referred resolutions that address reforming the Orphan Drug Act, legislation related to
50 an optional national prescription drug formulary, and modifications to the Hatch-Waxman Act
51 and Biologics Price Competition and Innovation Act (i.e., Biosimilars Act).

1 CONCLUSION

2
3 In the approximately two years since the TruthinRx grassroots campaign was launched, the
4 initiative has demonstrated significant success in engaging physicians, patients/consumers, and
5 health care policy influencers in discussion of and advocacy to improve prescription drug price and
6 cost transparency. As described above, the TruthinRx campaign is a key component of a broader,
7 ongoing AMA focus on prescription drug affordability, and *TruthinRx.org* will continue to evolve
8 as relevant AMA policy evolves. The objective metrics outlined above indicate that the TruthinRx
9 grassroots campaign is succeeding in stimulating public discourse, and *TruthinRx.org* will continue
10 to be updated to capture public attention and mobilize action.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-I-18

Subject: 2019 Strategic Plan

Presented by: Jack Resneck, Jr., MD, Chair

Our AMA continues to execute its multi-year strategy to achieve significant positive impact for physicians, medical students, and patients. The strategy, launched in 2013, identified three areas of emphasis in our mission areas: Improving Health Outcomes, Accelerating Change in Medical Education, and Shaping Care Delivery and Payment for Professional Satisfaction and Practice Sustainability. These areas have evolved to more encompassing strategic arcs: 1) improving the health of the nation by confronting the chronic disease burden, 2) reimagining medical education, training, and lifelong learning, and 3) attacking the dysfunction in health care by removing the obstacles and burdens that interfere with patient care. They provide for tangible and meaningful implementation of our AMA's mission to promote the art and science of medicine and the betterment of public health.

Through this report, the Board of Trustees affirms AMA's multi-year strategic focus. This report is devoted to what is on the horizon for each of these areas in 2019 and highlights other work to modernize the means through which physicians can engage in advancement of the mission.

ATTACKING THE DYSFUNCTION IN HEALTH CARE

With the continued dramatic shifts in the health care landscape putting more pressure on physicians and their practices, our work continues to focus on addressing the organizational and system level dysfunction that hinders physicians' ability to provide high quality patient care. Through our ongoing work, we are committed to making the patient-physician relationship more valued than paperwork, technology an asset and not a burden, and physician burnout a thing of the past. The goal is to create a future pathway for physicians to choose from a broad array of payment and health care delivery models, including viable fee-for-service options, which can provide a sustainable and satisfying physician practice. We are focused on improving—and setting a positive future path for—the operational, financial and technological aspects of a physician's practice.

Successful navigation and implementation of evolving public and private payment systems requires heightened physician awareness, informed assessment of options, and, potentially, new strategic and operating methods to optimize success. To support physicians through this changing landscape and improve care delivery and professional satisfaction, AMA will work in 2019 to:

- Advocate for legislative and regulatory changes that enhance prospects for physicians to succeed.
- Generate awareness and encourage physicians to prepare for evolving payment model changes.
- Provide multi-modal, multi-channel physician education about what new payment model options mean for physicians and patients.

- Guide physicians toward the best outcome in value-based care systems and establish the AMA as a valued source of support on issues spanning a wide range of care delivery and payment models.
- Expand the resources delivered through the STEPS Forward: Practice Improvement Strategies program and other tools to help physicians in a variety of practice settings learn new techniques to improve practice workflow, patient care and professional satisfaction.
- Increase the awareness and importance of professional satisfaction and support the Quadruple Aim through additional research, partnerships, and resources to assist physicians throughout the various settings and stages of their careers.
- Build on the foundation of prior years' work in the area of physician burnout and professional satisfaction by expanding our empirical research in and understanding of the organizational, system, and environmental factors that contribute to burnout with the aim of developing efficacious methods to defeat the problem at its source.
- Discover and promote the physician perspective across health technology sectors, directing development for improved usability, productive access to data, and respect for the patient-physician relationship.

In addition based on new AMA policy (Policy H-480.940, "Augmented Intelligence in Health Care") passed at A-18 we will build on our research and development capacity to further our understanding of how best to incorporate the emerging field of artificial intelligence into medical practice to preserve and enhance the patient physician relationship.

IMPROVING THE HEALTH OF THE NATION

Initiatives focused on health outcomes, particularly in the area of prevention and management of chronic care, underscore AMA's foundational commitment to improving the health of the nation. Concentrating on risk factors for cardiovascular disease and type 2 diabetes, our AMA is working with physicians and care teams to bring new approaches for anticipating, preventing, and managing widely prevalent chronic conditions. We have fixed on two ambitious long term goals:

- To have a nation where there is no incidence of preventable type 2 diabetes.
- To have a nation where all adults are meeting their blood pressure goals.

To achieve the scale required for this ambitious set of programs, AMA has developed multi-year strategic relationships with the Centers for Disease Control and Prevention (CDC) and the American Heart Association (AHA), whose national reach and influence reinforce and complement AMA resources. Our shared goals with the CDC and the AHA include significantly increasing the number of physician practices, health care systems and federally qualified health centers that:

- Screen patients for prediabetes and refer eligible patients to CDC-recognized diabetes prevention programs (DPPs) as the preferred option for preventing type 2 diabetes; and
- Improve care for patients with hypertension to achieve and sustain 70 percent or higher blood pressure control rates within the communities they serve.

AMA's partnerships with the CDC and AHA are solid and we are complementing them with collaborations with medical societies, business groups, payers, technology companies, and medical schools (through the ACE consortium) to offer evidence-based products, tools and services to support physicians, care teams, health system leaders and medical students in achieving the health outcomes we seek. Materials have been developed and distributed for use in practice settings ranging from small private practices to large integrated systems. The material and programs have been empirically demonstrated to be effective and our main focus is to create the environmental,

1 distribution, and awareness elements conducive to wide spread scaling. In this regard, we continue
2 to define and promote the “business case” for public and private payer coverage of proven
3 interventions such as diabetes prevention programs (for which Medicare began coverage in 2018)
4 and self-measured blood pressure monitoring devices. Looking forward in 2019, we intend to
5 blend the “best of” our prediabetes and hypertension work and add programming on cholesterol
6 management to assist physicians and care teams more comprehensively with cardiovascular risk
7 reduction for their patients.

8 9 REIMAGINE MEDICAL EDUCATION, TRAINING, AND LIFE LONG LEARNING

10
11 We are committed to a comprehensive approach to physician professional education and learning.
12 In 2019, the AMA will have mature and substantial effort in undergraduate medical education, be
13 expanding to graduate medical education and have a growing presence in physician lifelong
14 learning. These programs are designed to respond to the on the ground needs of physicians in the
15 evolving environment in which practice by utilizing modern adult education knowledge and digital
16 technology.

17
18 Since 2013 the AMA has supported a Consortium of medical schools, now 32 in number, to
19 accelerate change in medical education by creating a system that trains physicians to meet the
20 needs of today's patients and to anticipate future changes. Facilitated by the AMA through
21 individual and collaborative work the consortium schools have created new and innovative
22 programs and technologies that are increasingly adopted by medical schools throughout the nation.
23 Of particular note are the consortium’s health system science textbook that is being adopted by
24 more and more medical schools and the successful application of the chronic care curriculum based
25 on work done in our Improving Health Outcomes area. The latter is an example of the application
26 of work emanating from one strategic area to another critical arena.

27
28 The initial grant period of the Consortium ends in 2018, but due to the success of this collaboration
29 the schools have committed to continue to work together with AMA programmatic support to
30 sustain and grow this community of innovation, but without further grant funds. This is an example
31 of our efforts to cost effectively catalyze change through partnerships and collaborations. In 2019,
32 based on the experience and learning from the work in undergraduate medical education, we will
33 initiate a multi-year program to smooth the transition from medical school to residency through a
34 number of demonstration programs that include medical schools, residency programs, and
35 associated health systems.

36
37 In 2018, we continued to build education delivery capabilities with the development and launch of
38 the new AMA Ed Hub™ platform. The platform blends innovations in content, technology, and
39 user experience to deliver increasingly more personalized and compelling virtual learning
40 experiences to meet individual needs and preferences. AMA Ed Hub brings together the AMA’s
41 diverse educational offerings under one unified umbrella. Included are Learning™, STEPS
42 Forward™, GME Competency Education Program (GCEP), e-learning modules that support the
43 AMA’s Health Systems Science textbook, interactive micro-learning modules based on the AMA’s
44 modernized Code of Medical Ethics, curricula related to pain management, firearm safety and other
45 topics. As we look to 2019 and beyond, we will continue to build and enhance the platform as a set
46 of digital solutions that optimizes discovery of educational content for individual users, facilitates
47 delivery of an educational curriculum at an organization level, explores innovations in learning
48 experiences more closely connected to physicians’ daily practice, and expands automatic reporting
49 capabilities to support licensure and certification. We also will be exploring collaborations with
50 other organizations to advance both educational content and platform offerings.

1 ENGAGING PHYSICIANS AND ADVANCING THE MISSION

2
3 Our ambitions are high and we must utilize all available tools and assets to reach them. To this end
4 we wish to highlight three areas of leverage.

5
6 First, beginning in 2016 we have been building an innovation ecosystem that connects AMA
7 experience, knowledge, and mission priorities with technology and private sector groups. Our
8 wholly owned Silicon Valley situated subsidiary Health 2047 is a centerpiece of this effort.
9 Accessing world class technology, product development, and venture expertise it focuses on the
10 commercial complements of the AMA's strategic arcs. It has already founded a data
11 interoperability company and we anticipate several new ventures in 2019 that will address other
12 important areas that advance our mission.

13
14 Second, the goal of health equity is infused in all our strategic work. Each of the mission areas
15 have components directed toward the health equity goal. Based on guidance from the House and
16 with the support of the Board of Trustees in 2019 AMA management will establish a functional
17 hub that further facilitates and enhances concentration on this area. The unit's objective will be to
18 ensure optimal coordination, collaboration, and program development across the AMA's mission
19 areas in support of our commitment to national health equity.

20
21 Third, as evidence of AMA mission impact continues to grow, there is an opportunity for AMA to
22 deepen its engagement and strengthen its brand identity among physicians, students, residents and
23 other stakeholders. By leveraging more sophisticated approaches to identifying interests and needs
24 of the physician population, we can continuously improve our services and offerings to retain and
25 grow our membership base. We will create new connections, drive awareness and increase
26 opportunities to interact with the AMA using traditional and interactive/social/digital media,
27 building off our experience in 2018.

28
29 The momentum that supports this multi-year strategy is a reflection of collaboration and shared
30 commitment across the AMA and the Federation of medicine, academic institutions, public and
31 private health sector organizations, technology innovators, physicians, and physicians in training.
32 Together we will chart a course for health care delivery that will improve the health of the nation.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 1-I-18

Subject: Medical Tourism

Presented by: James E. Sabin, MD, Chair

1 INTRODUCTION

2
3 At the 2018 Annual Meeting, the American Medical Association (AMA) House of Delegates
4 adopted the recommendations of Council on Ethical and Judicial Affairs Report 3-A-18, “Medical
5 Tourism.” The Council issues this Opinion, which will appear in the next version of AMA
6 PolicyFinder and the next print edition of the *Code of Medical Ethics*.
7

8 E-1.2.13 – Medical Tourism

9
10 Medical tourists travel to address what they deem to be unmet personal medical needs,
11 prompted by issues of cost, timely access to services, higher quality of care or perceived
12 superior services, or to access services that are not available in their country of residence. In
13 many instances, patients travel on their own initiative, with or without consulting their
14 physician, and with or without utilizing the services of commercial medical tourism companies.
15 The care medical tourists seek may be elective procedures, medically necessary standard care,
16 or care that is unapproved or legally or ethically prohibited in their home system.
17

18 Many medical tourists receive excellent care, but issues of safety and quality can loom large.
19 Substandard surgical care, poor infection control, inadequate screening of blood products, and
20 falsified or outdated medications in lower income settings of care can pose greater risks than
21 patients would face at home. Medical tourists also face heightened travel-related risks. Patients
22 who develop complications may need extensive follow-up care when they return home. They
23 may pose public health risks to their home communities as well.
24

25 Medical tourism can leave home country physicians in problematic positions: Faced with the
26 reality that medical tourists often need follow-up when they return, even if only to monitor the
27 course of an uneventful recovery; confronted with the fact that returning medical tourists often
28 do not have records of the procedures they underwent and the medications they received, or
29 contact information for the foreign health care professionals who provided services, asked to
30 make right what went wrong when patients experience complications as a result of medical
31 travel, often having not been informed about, let alone part of the patient’s decision to seek
32 health care abroad. (IV, V, VI)

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

Physicians need to be aware of the implications of medical tourism for individual patients and the community.

Collectively, through their specialty societies and other professional organizations, physicians should:

- (a) Support collection of and access to outcomes data from medical tourists to enhance informed decision making.
- (b) Advocate for education for health care professionals about medical tourism.
- (c) Advocate for appropriate oversight of medical tourism and companies that facilitate it to protect patient safety and promote high quality care.
- (d) Advocate against policies that would require patients to accept care abroad as a condition of access to needed services.

Individually, physicians should:

- (e) Be alert to indications that a patient may be contemplating seeking care abroad and explore with the patient the individual's concerns and wishes about care.
- (f) Seek to familiarize themselves with issues in medical tourism to enable them to support informed decision making when patients approach them about getting care abroad.
- (g) Help patients understand the special nature of risk and limited likelihood of benefit when they desire an unapproved therapy. Physicians should help patients frame realistic goals for care and encourage a plan of care based on scientifically recognized interventions.
- (h) Advise patients who inform them in advance of a decision to seek care abroad whether the physician is or is not willing to provide follow-up care for the procedure(s), and refer the patient to other options for care.
- (i) Offer their best professional guidance about a patient's decision to become a medical tourist, just as they would any other decision about care. This includes being candid when they deem a decision to obtain specific care abroad not to be in the patient's best interests. Physicians should encourage patients who seek unapproved therapy to enroll in an appropriate clinical trial.
- (j) Physicians should respond compassionately when a patient who has undergone treatment abroad without the physician's prior knowledge seeks nonemergent follow-up care. Those who are reluctant to provide such care should carefully consider:
 - (i) the nature and duration of the patient-physician relationship;
 - (ii) the likely impact on the individual patient's well-being;
 - (iii) the burden declining to provide follow-up care may impose on fellow professionals;
 - (iv) the likely impact on the health and resources of the community.

Physicians who are unable or unwilling to provide care in these circumstances have a responsibility to refer the patient to appropriate services. (IV, V, VI)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS^{1*}

CEJA Opinion 2-I-18

Subject: Expanded Access to Investigational Therapies

Presented by: James E. Sabin, MD, Chair

INTRODUCTION

At the 2018 Annual Meeting, the American Medical Association (AMA) House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 4-A-18, “Expanded Access to Investigational Therapies.” The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-7.3.10 – Expanded Access to Investigational Therapies

Physicians who care for patients with serious, life-threatening illness for whom standard therapies have failed, are unlikely to be effective, or do not exist should determine whether questions about access to investigational therapy through the U.S. Food and Drug Administration’s “expanded access” program are likely to arise in their clinical practice. If so, physicians should familiarize themselves with the program to be better able to engage in shared decision making with patients.

When a patient requests expanded access to an investigational therapy, physicians should:

- (a) Assess the patient’s individual clinical situation to determine whether an investigational therapy would be appropriate, including:
 - (i) whether there is a satisfactory alternative therapy available to diagnose, monitor, or treat the patient’s disease or condition;
 - (ii) the nature of potential risks of the investigational therapy and whether those risks are not unreasonable in the context of the patient’s disease or condition;
 - (iii) whether the potential benefit to the patient justifies the risks of the investigational therapy;
 - (iv) whether the patient meets inclusion criteria for an existing clinical trial of the investigational therapy.

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1 (b) As part of the informed consent process, advise the patient (or parent/guardian if the
2 patient is a minor) that the investigational therapy has not yet been demonstrated to be
3 effective in treating the patient's condition and may pose as yet unknown risks.
4 Physicians should explain the importance of clinical trials, encourage patients who meet
5 inclusion criteria to participate in an existing trial rather than seek access to
6 investigational therapy through the FDA expanded access program, and direct patients
7 who wish to participate in research to appropriate resources.
8

9 (c) Decline to support an application for expanded access to an investigational therapy
10 when:
11

- 12 (i) the physician judges the treatment with the investigational therapy not to be in the
13 patient's best interest, and explain why; or
14
15 (ii) the physician does not have appropriate resources and ability to safely supervise
16 the patient's care under expanded access.
17

18 In such cases, physicians should refer the patient to another physician with whom to discuss
19 possible application for expanded access.
20

21 (d) Discuss the implications of expanded access for the patient and family and help them
22 form realistic expectations about what it will mean to be treated with the investigational
23 therapy outside a clinical trial. Physicians should alert patients:
24

- 25 (i) to the possibility of financial or other responsibilities associated with receiving an
26 investigational therapy through expanded access;
27
28 (ii) to the lack of infrastructure to systematically monitor and evaluate the effects of
29 the investigational therapy outside a clinical trial;
30
31 (iii) that they need information about how to contact the manufacturer for guidance if
32 they seek emergency care from a health care professional who is not affiliated with
33 a clinical trial of the investigational therapy;
34
35 (iv) that the physician has a responsibility to collect and share clinical information
36 about the patient's course of treatment with the investigational therapy, as well as
37 to report any adverse events that may occur over the course of treatment;
38
39 (v) to the conditions under which the physician would recommend stopping treatment
40 with the investigational therapy. (V,VI)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 3-I-18

Subject: Mergers of Secular and Religiously Affiliated Health Care Institutions

Presented by: James E. Sabin, MD, Chair

1 INTRODUCTION

2
3 At the 2018 Annual Meeting, the American Medical Association (AMA) House of Delegates
4 adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-A-18, “Mergers
5 of Secular and Religiously Affiliated Health Care Institutions.” The Council issues this Opinion,
6 which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code*
7 *of Medical Ethics*.
8

9 E-11.2.6 – Mergers of Secular and Religiously Affiliated Health Care Institutions

10
11 The merger of secular health care institutions and those affiliated with a faith tradition can
12 benefit patients and communities by sustaining the ability to provide a continuum of care
13 locally in the face of financial and other pressures. Yet consolidation among health care
14 institutions with diverging value commitments and missions may also result in limiting what
15 services are available. Consolidation can be a source of tension for the physicians and other
16 health care professionals who are employed by or affiliated with the consolidated health care
17 entity.
18

19 Protecting the community that the institution serves as well as the integrity of the institution,
20 the physicians and other professionals who practice in association with it, is an essential, but
21 challenging responsibility.
22

23 Physician-leaders within institutions that have or are contemplating a merger of secular and
24 faith-based institutions should:
25

- 26 (a) Seek input from stakeholders to inform decisions to help ensure that after a consolidation
27 the same breadth of services and care previously offered will continue to be available to the
28 community.
29
30 (b) Be transparent about the values and mission that will guide the consolidated entity and
31 proactively communicate to stakeholders, including prospective patients, physicians, staff,
32 and civic leaders, how this will affect patient care and access to services.

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1 (c) Negotiate contractual issues of governance, management, financing, and personnel that
2 will respect the diversity of values within the community and at minimum that the same
3 breadth of services and care remain available to the community.

4
5 (d) Recognize that physicians' primary obligation is to their patients. Physician-leaders in
6 consolidated health systems should provide avenues for meaningful appeal and advocacy
7 to enable associated physicians to respond to the unique needs of individual patients.

8
9 (e) Establish mechanisms to monitor the effect of new institutional arrangements on patient
10 care and well-being and the opportunity of participating clinicians to uphold professional
11 norms, both to identify and address adverse consequences and to identify and disseminate
12 positive outcomes.

13
14 Individual physicians associated with secular and faith-based institutions that have or propose
15 to consolidate should:

16
17 (f) Work to hold leaders accountable to meeting conditions for professionalism within the
18 institution.

19
20 (g) Advocate for solutions when there is ongoing disagreement about services or arrangements
21 for care. (VII, VIII, IX)

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-I-18

Subject: Review of AMA Educational Offerings

Presented by: Carol Berkowitz, MD, Chair

INTRODUCTION

The Council on Medical Education has been gratified to observe our American Medical Association's (AMA) committed investment in and focus on the development and provision of high-quality educational resources and initiatives for physicians and physicians in training, and is pleased to be able to highlight these to members of the House of Delegates (HOD).

THE EARLY YEARS: THE AMA'S COUNCIL ON MEDICAL EDUCATION

Our AMA's commitment to medical education dates to the founding of the Association in 1847, when one of its first acts was to appoint a body known as the Committee on Medical Education. The Committee on Medical Education was transformed into the Council on Medical Education in 1904; an addition to AMA bylaws in that year noted that:

The functions of the Council on Medical Education shall be:

- To make an annual report to the House of Delegates on the existing conditions of medical education in the United States.
- To make suggestions as to the means and methods by which the American Medical Association may best influence favorably medical education.
- To act as the agent of the American Medical Association (under instructions from the House of Delegates) in its efforts to elevate medical education.¹

In 1905, the Council published its first set of educational standards for medical schools, recommending (1) that medical schools require preliminary education sufficient to enable the candidate to enter a recognized university; (2) a 5-year medical course; and (3) a sixth year as an intern in the hospital.²

In 1906, the Council, tasked with rating U.S. medical schools, surveyed 160 schools regarding the performance of graduates on state licensure examinations. Schools were graded as acceptable, doubtful, or non-acceptable based on a set of ten defined qualifications. Only 82 schools received an "acceptable" rating. This led to the Council's 1909 partnership with the Carnegie Foundation on a new study of medical schools; the results of this study were published in 1910 in the Flexner Report.³

In the intervening years, our AMA, through the Council on Medical Education and other groups, has been involved in the establishment of many of the leading U.S. medical education organizations that exist today and with the development of multiple educational innovations. These organizations and innovations are summarized in Appendix A.

EXPANDING OUR AMA'S EDUCATION DEVELOPMENT AND DELIVERY CAPABILITIES

Our AMA has recently dedicated additional resources and staff to its educational initiatives, and as a result, numerous innovations are being developed.

Content

In-house instructional design capabilities have been enhanced, and measures have been taken to ensure educational content incorporates learning trends that engage adult learners. Additionally, our AMA has developed a library of templated eLearning interactions, which can be leveraged across the organization in content development efforts. A robust quality rubric has been implemented to guide the planning, development, and evaluation of education. The rubric helps to ensure that education is well-designed and likely to result in achieving the desired learning outcomes. Finally, the assessment creation process has been improved to better evaluate mastery of learning objectives.

Platform

Our AMA plans to launch a unified education delivery platform known as the AMA Ed Hub™. The AMA Ed Hub™ will bring together our AMA's diverse educational offerings under a unified umbrella, including [JN Learning™](#); the [GME Competency Education Program](#) (GCEP); e-learning modules that support our AMA's *Health Systems Science* (HSS) textbook; interactive micro-learning modules based on our AMA's modernized [Code of Medical Ethics](#); the [STEPS Forward™](#) practice transformation series; and curricula related to pain management, firearm safety, and other topics.

The platform will blend innovations in content, technology, and user experience to deliver increasingly more personalized and compelling virtual learning experiences to meet individual needs and preferences. Additionally, it will feature trusted education in engaging and multi-dimensional formats to satisfy a variety of preferences (audio, interactive, journal, and video). The platform is designed to facilitate easy discovery of relevant education. All content is standardized, tagged, and enriched in a way that allows our AMA to actively engage learners by offering content across many channels, sites, apps, and products.

OUR AMA'S EDUCATIONAL INITIATIVES AND RESOURCES

Our AMA is also proactively seeking cooperation between business units to mine additional educational content, more effectively leverage subject matter expertise across products, and expand target audiences. For example, authors of the HSS textbook have extended their contributions beyond medical school to residency by contributing to the development of GME Competency Education Program educational modules. Also, education regarding physician burnout has been repackaged to focus on burnout at the resident physician level.

Accelerating Change in Medical Education Consortium innovations

Our AMA's [Accelerating Change in Medical Education](#) initiative, launched in 2013, has fostered a culture of medical education advancement, leading to the development and scaling of innovations at the undergraduate medical education level across the country. After awarding initial grants to 11 U.S. medical schools, the AMA convened these schools to form the Accelerating Change in Medical Education Consortium—an unprecedented collective that facilitated the development and

1 communication of groundbreaking ideas and projects. The AMA awarded grants to an additional
2 21 schools in 2016. Today, almost one-fifth of all U.S. allopathic and osteopathic medical schools
3 are represented in the 32-member consortium, which is delivering revolutionary educational
4 experiences to approximately 19,000 medical students—students who one day will provide care to
5 a potential 33 million patients annually.

6
7 A summary of innovations resulting from the Consortium can be found in Appendix B.
8 Additionally, a comprehensive, annotated bibliography of publications based on the work of the
9 Consortium has been published and is available for review.⁴

10 11 *Innovative Educational Formats in the JAMA Network*

12
13 The JN Listen™ app provides learners with convenient access to engaging podcasts based on peer-
14 reviewed articles published in *JAMA*. Learners can listen to content they select and earn CME, all
15 via the mobile app.

16 17 *STEPS Forward™*

18
19 The AMA STEPS Forward™ practice transformation series is an online educational product
20 designed to offer innovative strategies that assist physicians in the new health care environment.
21 Leveraging findings from an AMA-RAND study,⁵ the online modules provide clinicians and
22 practice managers with the data, tools, education, and certification needed to be successful in a
23 value-based payment environment. Learners can take courses about patient care, workflow and
24 process, and professional well-being, among other topics. All STEPS Forward™ modules are
25 Centers for Medicare & Medicaid Services-approved Clinical Practice Improvement Activities; by
26 completing these modules, physicians can demonstrate compliance with Merit-Based Incentive
27 Payment System requirements.

28
29 Recently, each of the 48 available modules' learning objectives and assessments were revised to
30 ensure that learner expectations and outcomes are aligned. Content is currently being converted to a
31 standardized format for multichannel publication.

32 33 *GME Competency Education Program*

34
35 The AMA GME Competency Education Program (GCEP) comprises a series of online educational
36 modules designed to complement teaching in patient settings and didactic curricula in residency
37 and fellowship programs. The program helps residents and their institutions meet core competency
38 requirements. In 2018, GCEP was selected as a Gold winner in the 2018 Digital Health Awards,
39 which recognizes high-quality digital health resources for health professionals.

40
41 Over the past year, the 33-module GCEP library has been upgraded to add animation, case
42 vignettes, and mock simulations to help residents visualize how the content is applicable to their
43 daily practice. The final eight modules are currently being enhanced, including content on quality
44 improvement practices, promoting medication adherence, navigating a lawsuit, and creating an
45 effective and respectful learning environment, among other topics. Personalized instruction has
46 been incorporated, as well as guided learning using relatable mentor characters.

47 48 *Health Systems Science*

49
50 In addition to basic and clinical sciences, recognition is growing that physicians also need to know
51 HSS, understanding how care is delivered, how patients receive that care, and how systems

function to improve health. By the end of 2018, the AMA plans to have completed six e-learning modules for medical students that complement the HSS textbook, with the goal of providing a cohesive introduction to HSS. While the initial target audience is medical students, faculty development components will be included. Eventually, a parallel learning strategy for faculty and residents is also envisioned. Current modules in development include systems thinking, patient safety, and population health.

Ethics

In 2017, our AMA adopted the modernized *Code of Medical Ethics*,⁶ and new, interactive micro-learning modules have been created around key *Code* opinions. In 2018, the AMA has been developing new modules on privacy and confidentiality, surrogates, and physicians as leaders.

Health Equity

To support the work stemming from our AMA's newly adopted policy related to health equity,⁷ a new module has been launched titled Collecting Patient Data: Improving Health Equity in Your Practice.

The AMA Physician's Recognition Award and Credit System

The AMA Physician's Recognition Award (PRA), established by the HOD in December 1968 and celebrating its 50th anniversary in 2018, recognizes physicians who, by participating in CME activities, have demonstrated their commitment to staying current with advances in medicine. The AMA PRA credit system was developed to describe CME activities with sufficient educational value that could be counted towards the requirements to obtain the PRA. AMA PRA credit is the most widely accepted CME credit used by physicians of all specialties to document CME participation for licensing boards, certification boards, hospital credentialing committees, insurance groups, and other organizations.

The AMA PRA credit system has continued to respond to the needs of physicians and to changes in the practice of medicine. Recognizing that physicians learn in different ways and that a variety of educational formats should be recognized for credit, the Council on Medical Education has approved new educational formats for *AMA PRA Category 1 Credit*TM over the years in addition to the original formats of live certified activities and enduring materials. Subsequently approved formats include Journal-Based CME (1998), Manuscript Review (2003), Test Item Writing (2003), Performance Improvement CME (2004), and Internet Point-of-Care (2005). Most recently, in 2017, the Council on Medical Education approved a format of "Other" for those activities that meet core requirements but do not fall within one of the already existing formats.

The AMA PRA credit system also operates beyond U.S. borders. In 1990, the HOD adopted a Council on Medical Education report to establish a process for qualified international conferences to offer *AMA PRA Category 1 Credit*TM to attendees. The International Conference Recognition Program continues to this day, and international opportunities to earn *AMA PRA Category 1 Credit*TM have expanded to include activities covered by agreements between the AMA and the credit systems of other regions and nations. Three agreements currently exist, with the European Union of Medical Specialists, the Royal College of Physicians and Surgeons of Canada, and the Qatar Council for Healthcare Practitioners.

1 *Section/Council Educational Sessions*

2
3 Since 2014, AMA sections and/or councils have produced approximately 120 educational sessions
4 at the Annual and Interim meetings (15 sessions per meeting, on average), in addition to various
5 other activities provided throughout the years. Nationally renowned experts, including many AMA
6 members, have educated on important and timely topics, such as physician burnout, the opioid
7 epidemic, firearm safety, value-based care, physician leadership, and innovation.
8

9 *Collaboration with External Organizations*

10
11 Our AMA continues to work to lessen the administrative burden for physicians by simplifying and
12 streamlining the automatic tracking and reporting of credit to support certification and licensure
13 needs. Currently, our AMA partners with the ACCME and ABIM to report completed JAMA
14 Network CME activities on behalf of physicians certified by the ABIM. The AMA will extend
15 these reporting capabilities to include all AMA educational activities and additional ABMS
16 member boards in 2019. Finally, a pilot is being planned with the ACCME and Board of Medical
17 Examiners in Tennessee to report completed activities on behalf of physicians licensed in
18 Tennessee.
19

20 Our AMA has also been approved as an ABMS Multi-Specialty Portfolio Program sponsor and has
21 developed CME programs that are eligible for continuing certification (MOC Part IV) credit.
22

23 *Future Innovations*

24
25 Additional planned innovations will focus on educational features and apps that offer innovation in
26 the education space. Currently, our AMA is:
27

- 28 • Leveraging augmented intelligence to power learning experiences;
- 29 • Taking new approaches to documenting meaningful involvement in performance
30 improvement; and
- 31 • Considering different types of assessment, which could expand the content for which credit
32 can be offered.
33

34 Finally, our AMA is also exploring the potential of the AMA Ed Hub™ platform to be of service to
35 other educational providers.
36

37 **SUMMARY**

38
39 For 150 years, our AMA has demonstrated a commitment to developing and supporting
40 advancements in medical education, both autonomously and in partnership with others. From the
41 Council on Medical Education's contributions to the Flexner Report, to the groundbreaking
42 Accelerating Change in Medical Education Consortium, to newly enhanced e-learning content
43 design and delivery, our AMA is well positioned to lead medical education innovations into the
44 next century.

APPENDIX A: THE AMA'S INFLUENCE IN ESTABLISHING MANY LEADING U.S. MEDICAL EDUCATION ORGANIZATIONS AND DEVELOPING EDUCATIONAL INNOVATIONS

- | | |
|------|--|
| 1847 | The American Medical Association is organized and the Committee on Medical Education is formed. |
| 1904 | The AMA transforms the Committee on Medical Education into the Council on Medical Education (Council). |
| 1905 | The Council publishes its first set of educational standards for medical schools. |
| 1906 | The Council performs its first inspection of medical schools. |
| 1910 | The Council's partnership with the Carnegie Foundation leads to the publication of the Flexner Report. |
| 1912 | The Council fields its first survey of hospitals for the training of interns. |
| 1919 | The Council establishes the "Essentials" for approved Internships. |
| 1920 | The Council organizes 15 committees to study and "recommend what preparation was deemed essential to secure expertness in each of the specialties"; these committees represent the forerunners of today's boards. |
| 1927 | The Council begins approval of residency programs in hospitals. |
| 1928 | The Council establishes "Essentials" for registered hospitals and for approved residencies and fellowships. |
| 1934 | The Council approves examining boards for the certification of specialists and establishes standards for the formation of American boards in the specialties. |
| 1939 | The Council, with the American Board of Internal Medicine (ABIM) and American College of Physicians (ACP), forms the Conference Committee on Graduate Training in Internal Medicine, later to become the Residency Review Committee for Internal Medicine; other specialty boards soon request their own committees. |
| 1942 | At the request of the Council, the AMA Board of Trustees and the Association of American Medical Colleges (AAMC) form the Liaison Committee on Medical Education (LCME). |
| 1948 | The Council and the Advisory Board for Medical Specialties establish the Liaison Committee for Specialty Boards. |
| 1950 | The Council establishes the Conference Committee on Graduate Training in Surgery. |
| 1954 | With representation from the Council, the AAMC, the American Hospital Association (AHA), and the Federation of State Medical Boards (FSMB), an Internship Review Committee is established to review the reports of surveys of intern training programs made by members of the Council's field staff. |

- 1955 Based on work performed by the Council, the “Publication of Postgraduate Medical Education in the United States: A Report of the Survey of Postgraduate Medical Education Carried Out by the Council on Medical Education and Hospitals” is published.
- 1957 A guide on postgraduate medical education (continuing medical education) is issued.
- 1957 With the AHA, AAMC, and FSMB, the Council sponsors the organization of the Educational Commission for Foreign Medical Graduates (ECFMG).
- 1962 The AMA completes the first accreditation survey of continuing medical education (CME) sponsors; the lists of accredited sponsors are published in *JAMA*.
- 1967 The Advisory Committee on Continuing Medical Education, of the AMA House of Delegates, develops a nationwide accreditation system for CME providers.
- 1968 The AMA establishes the AMA Physician’s Recognition Award (PRA) to recognize physicians who earn at least an average of 50 credits per year from educational activities that meet AMA standards and the AMA PRA CME credit system.
- 1970 The Advisory Board for Medical Specialties is reorganized as the American Board of Medical Specialties (ABMS).
- 1971 The Council establishes the Liaison Committee on Graduate Medical Education, which later becomes the Accreditation Council for Graduate Medical Education (ACGME).
- 1977 The Council establishes the Liaison Committee on Continuing Medical Education (LCCME).
- 1981 The AMA, with the AAMC, AHA, FSMB, ABMS, Association for Hospital Medical Education, and Council of Medical Specialty Societies, creates the Accreditation Council for Continuing Medical Education (ACCME) as successor to the LCCME for the accreditation of CME sponsors.
- 1982 CME Report B, Recommendations for “Future Directions for Medical Education,” is adopted by the AMA House of Delegates.
- 1987 CME Report C, “Resident Working Hours and Supervision,” is adopted by the AMA House of Delegates.
- 1991 The AMA’s Fellowship and Residency Electronic Interactive Data Access (FREIDA) System is established.
- 1996 The Council on Medical Education approves *AMA PRA Category 1 Credit™* for reading journal articles.
- 1996 AMA FREIDA becomes AMA FREIDA Online®.

- 2000 The Council approves its first international agreement for the conversion of CME credits, providing physicians the opportunity to receive *AMA PRA Category 1 Credit™* for attending European Union of Medical Specialists educational activities certified for credit. Other agreements would follow.
- 2002 CME Report 9, “Resident Physician Working Conditions,” is adopted by the AMA House of Delegates.
- 2003 The Council on Medical Education approves *AMA PRA Category 1 Credit™* for test item writing and manuscript review learning formats.
- 2004 The Council on Medical Education approves *AMA PRA Category 1 Credit™* for Performance Improvement CME (PI CME) learning format.
- 2005 The Council on Medical Education approves *AMA PRA Category 1 Credit™* for Internet Point of Care learning format.
- 2005 The AMA embarks on its Initiative to Transform Medical Education (ITME).
- 2006 The Alliance for CME awards the AMA the Frances M. Maitland PACME Award for “significant contribution to the field of CME and the future of the profession.”
- 2006 The AMA trademarks the phrase *AMA PRA Category 1 Credit™*.
- 2006 Phase 2 of ITME begins, resulting in recommendations for change across the continuum to address identified gaps in medical education.
- 2007 Phase 3 of ITME begins with a working conference on Optimizing the Medical Education Learning Environment.
- 2008 Phase 3 of ITME continues with a conference in collaboration with the American Academy of Pediatrics on Physician Reentry into Practice.
- 2009 The AMA and Association of American Medical Colleges hold ITME Conference on Increasing Attention to Behavioral Competencies in the Admissions Process.
- 2010 The AMA and AAMC co-sponsor an invitational conference, “New Horizons in Medical Education: A Second Century of Achievement.”
- 2011 The AMA Innovative Strategies for Transforming the Education of Physicians (ISTEP) research collaborative begins the second stage of its study of the medical education learning environment.
- 2012 The AMA announces a new strategic plan to focus on Accelerating Change in Medical Education as one of its three main focus areas.
- 2012 The AMA and AAMC sign a formal agreement that outlines their joint, ongoing commitment to supporting the medical education accreditation process.

- 2013 The AMA announces grant funding for medical school innovations and awards \$11 million to 11 medical schools nationwide as part of its Accelerating Change in Medical Education initiative.
- 2013 The AMA PRA recognizes teaching students and residents as an *AMA PRA Category 1 Credit™* activity.
- 2013 The AMA launches its Save GME grassroots campaign (saveGME.org) to urge Congress to preserve GME funding and lift the federal cap on residency slots.
- 2014 The AMA is among the four signers of a formal agreement between the LCME and the Committee on Accreditation of Canadian Medical Schools (CACMS) to ensure medical school graduates in both the United States and Canada meet their respective countries' standards and are prepared for the next phase of their medical training.
- 2014 The Council on Medical Education convenes a conference with the ABMS and its member boards to discuss ways to improve Maintenance of Certification and make the process more meaningful for physicians.
- 2015 The AMA awards grants to an additional 21 medical schools as a part of the Accelerating Change in Medical Education Consortium, further expanding this community of learning.
- 2018 The Council on Medical Education co-convenes a second conference with the ABMS and its member boards to discuss the future of continuing certification.

APPENDIX B: SUMMARY OF CONSORTIUM INNOVATIONS IN MEDICAL EDUCATION⁸

INNOVATION FOCUS	SUMMARY	PUBLICATIONS AND OUTCOMES
Developing flexible, competency-based pathways	<p>Medical education at all levels is shifting away from emphasizing time spent in lectures and classrooms and toward establishing that the necessary knowledge and skills have been acquired. Medical schools are incorporating milestones and entrustable professional activities (EPAs) into the curriculum to determine the best path for students to follow in order to move to the next level of training.</p> <p>These flexible, competency-based pathways create physicians who are comfortable assessing their abilities and addressing any deficiencies throughout their careers.</p>	<p>Generalizing Competency Assessment Scores Across and Within Clerkships⁹</p> <p>Finding a Path to Entrustment in Undergraduate Medical Education¹⁰</p> <p>Constructing a Shared Mental Model for Faculty Development in CEPAER¹¹</p>
Teaching new content in Health Systems Science	<p>To fully serve patients, physicians must know more than biomedical and clinical sciences. The new discipline of health systems science includes understanding how to improve health care quality, increase value, enhance patient safety, deliver population-based care, and work collaboratively in teams.</p> <p>Physicians need to learn how to advocate for their patients and communities and understand the socio-ecological determinants of health, health care policy, and health care economics.</p>	<p><i>Health Systems Science</i>¹²</p> <p>Investigate the Barriers to Integrating Health Systems Science in Medical Education¹³</p> <p>Science of Health Care Delivery Milestones for Undergraduate Medical Education¹⁴</p>
Working with health care delivery systems in novel ways	<p>Consortium schools are creating new learning experiences embedded within health care systems.</p> <p>Training students to be patient navigators, to plan and execute quality improvement projects, and to perform important functions that benefit patient-centered teams serve dual purposes. Students learn about health care delivery by working in authentic settings and are able to contribute to</p>	<p>How Can Medical Students Add Value? Identifying Roles, Barriers, and Strategies to Advance the Value of Undergraduate Medical Education to Patient Care and the Health System.¹⁵</p> <p>Socially Accountable Medical Education: An Innovative Approach at Florida International University</p>

	improving the health of patients in meaningful ways.	Herbert Wertheim College of Medicine ¹⁶ Value-Added Clinical Systems Learning Roles for Medical Students That Transform Education and Health: A Guide for Building Partnerships Between Medical Schools and Health Systems ¹⁷
Making technology work for learning	<p>Consortium schools are adapting technology in new ways to solve key problems and advance physician training. They are teaching the use of EHRs, management of patient panels to improve health outcomes, and interpretation of big data.</p> <p>In addition, schools are applying learning technology to manage individualized, flexible progress by assessing student competencies along their medical education journey. New tools are being used to compile assessment data that will allow for easier self-assessment by students and review with faculty coaches.</p>	<p>Regenstrief EHR Clinical Learning Platform¹⁸</p> <p>Barriers to Medical Students' Electronic Health Record Access Can Impede Their Preparedness for Practice.¹⁹</p> <p>NYU Langone Health: Healthcare by the Numbers: Populations, Systems, and Clinically Integrated Data²⁰</p>
Envisioning the master adaptive learner	<p>Physicians need to rapidly access and interpret continuously evolving information and to understand how the use of new data supports the delivery of the best patient care.</p> <p>One of the aims of the consortium is to assist physicians in becoming master adaptive learners—expert, self-directed, self-regulated and lifelong workplace learners.</p>	<p>Fostering the Development of Master Adaptive Learners: A Conceptual Model to Guide Skill Acquisition in Medical Education.²¹</p> <p>Mission Control: The Gamification of Medical Learning²²</p>
Shaping tomorrow's leaders	<p>Future physicians will need to do more than deliver high-quality care. To be effective in the health care system of tomorrow, they will need to possess the ability to lead teams and participate in positive change. Consortium schools are integrating leadership and teamwork training into curricula that will prepare today's medical students to become future leaders.</p>	<p>Shifting the Curve: Fostering Academic Success in a Diverse Student Body²³</p> <p>Medical Student Perceptions of the Learning Environment: Learning Communities Are Associated With a More Positive Learning Environment in a Multi-Institutional Medical School Study²⁴</p>

Universal outcomes		<p>Coaching Handbook²⁵</p> <p>Curricular Transformation: The Case Against Global Change²⁶</p> <p>Why Not Wait? Eight Institutions Share Their Experiences Moving United States Medical Licensing Examination Step 1 After Core Clinical Clerkships.²⁷</p> <p>Turn Med Ed on its Head: Medical Education Innovation Challenge.²⁸</p>
Creating an online community	<p>Participants in this online community are discussing developments and innovations in medical education, including the work emerging from the AMA's Accelerating Change in Medical Education Consortium, as part of the AMA's work to create the medical schools of the future. Webinars educate and connect participants and help spread innovations nationally.</p>	<p>Implementing a Teaching EHR as a Clinical Learning Platform²⁹</p> <p>Transforming Education: Leading Innovations in Health Professions Education³⁰</p> <p>Using Big Data to Teach Population Health³¹</p> <p>Health Systems Science: The Third Pillar of Medical Education³²</p> <p>Interprofessional Education: Using Technology to Teach Team-Based Care³³</p> <p>To Medical Student Wellness and Beyond: Creating a Healthy Culture for All³⁴</p> <p>Leadership Training: Developing the Next Generation of Physician Leaders</p> <p>Portfolios and Dashboards: Leveraging Data for Student Success</p>

REFERENCES

- ¹ American Medical Association. A History of the Council on Medical Education and Hospitals of the American Medical Association. Chicago, IL: W.B. Saunders Company; 1957.
- ² Barzansky B. Abraham Flexner and the Era of Medical Education Reform. *Acad Med.* 2010;85:S19-S25.
- ³ Flexner, A. Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching. The Carnegie Foundation for the Advancement of Teaching, Bulletin No. 4. Available at http://archive.carnegiefoundation.org/pdfs/elibrary/Carnegie_Flexner_Report.pdf. Accessed July 17, 2018.
- ⁴ American Medical Association. Creating a Community of Innovation. 2nd Ed. Available at <https://www.ama-assn.org/sites/default/files/media-browser/18-214089-ACE-annotated%20bibliography%20updates-online%20v2.pdf>. Accessed July 30, 2018.
- ⁵ Friedberg MW, Chen PG, Van Busum KR et al. Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. Santa Monica, CA: RAND Corporation, 2013. Available at https://www.rand.org/pubs/research_reports/RR439.html. Accessed July 17, 2018.
- ⁶ American Medical Association. Code of Medical Ethics. Chicago, IL: American Medical Association; 2017.
- ⁷ American Medical Association. Plan for Continued Progress Toward Health Equity. Policy H-180.944. Available at <https://policysearch.ama-assn.org/policyfinder/detail/plan%20for%20continued%20progress?uri=%2FAMADoc%2FHOD.xml-H-180.944.xml>. Accessed July 31, 2018.
- ⁸ American Medical Association. Innovations and Outcomes of the Consortium. Available at <https://www.ama-assn.org/innovations-outcomes-consortium>. Accessed July 17, 2018.
- ⁹ Zaidi NLB, Kreiter CD, Castaneda, PR et al. Generalizability of Competency Assessment Scores Across and Within Clerkships: How Students, Assessors, and Clerkships Matter. *Acad Med.* April 24, 2018. doi: 10.1097/ACM.0000000000002262. [Epub ahead of print]
- ¹⁰ Brown DR, Warren JB, Hyderi A et al. Finding a Path to Entrustment in Undergraduate Medical Education: A Progress Report From the AAMC Core Entrustable Professional Activities for Entering Residency Entrustment Concept Group. *Acad Med.* 2017;92(6):774-779.
- ¹¹ Favreau MA, Tewksbury L, Lupi C. Constructing a Shared Mental Model for Faculty Development for the Core Entrustable Professional Activities for Entering Residency. *Acad Med.* 2017;92(6):759-764.
- ¹² Skochelak SE, Hawkins RE, Lawson LE et al. *Health Systems Science*. Philadelphia, PA: Elsevier; 2017.
- ¹³ Gonzalo JD, Caverzagie KJ, Hawkins RE et al. Concerns and Responses for Integrating Health Systems Science Into Medical Education. *Acad Med.* 2018;93(6):843-849.
- ¹⁴ Havyer RD, Norby SM, Hunderfund ANL et al. Science of health care delivery milestones for undergraduate medical education. *BMC Med Educ.* Available at <https://bmcmmededuc.biomedcentral.com/track/pdf/10.1186/s12909-017-0986-0>. Accessed July 17, 2018.
- ¹⁵ Gonzalo JD, Dekhtyar M, Hawkins RE et al. How Can Medical Students Add Value? Identifying Roles, Barriers, and Strategies to Advance the Value of Undergraduate Medical Education to Patient Care and the Health System. *Acad Med.* 2017;92(9):1294-1301.
- ¹⁶ Greer PJ Jr., Brown DR, Brewster LG et al. Socially Accountable Medical Education: An Innovative Approach at Florida International University Herbert Wertheim College of Medicine. *Acad Med.* 2018;93(1):60-65.
- ¹⁷ Gonzalo JD, Lucey C, Wolpaw T, et al. Value-Added Clinical Systems Learning Roles for Medical Students That Transform Education and Health: A Guide for Building Partnerships Between Medical Schools and Health Systems. *Acad Med.* 2017;92(5):602-607.
- ¹⁸ <https://clinicallearning.how/>.
- ¹⁹ Welcher CM, Hersh W, Takesue B et al. Barriers to Medical Students' Electronic Health Record Access Can Impede Their Preparedness for Practice. *Acad Med.* 2018;93(1):48-53.
- ²⁰ New York University Langone Health. Healthcare by the Numbers: Populations, Systems, and Clinically Integrated Data. Available at <https://ace.iime.cloud/>. Accessed June 17, 2018.
- ²¹ Cutrer WB, Miller B, Pusic MV. Fostering the Development of Master Adaptive Learners: A Conceptual Model to Guide Skill Acquisition in Medical Education. *Acad Med.* 2017;92(1):70-75.

- ²² Rahman SS. Mission Control: The Gamification of Medical Learning. Talk presented at: American Medical Association, ChangeMedEd™ 2015 Conference. September 2015. Chicago, IL. <https://www.ama-assn.org/education/envisioning-master-adaptive-learner>. Accessed July 17, 2018.
- ²³ Elks ML, Herbert-Carter J, Smith M et al. Shifting the Curve: Fostering Academic Success in a Diverse Student Body. *Acad Med*. 2018;93(1):66-70.
- ²⁴ Smith SD, Dunham L, Dekhtyar M et al. Medical Student Perceptions of the Learning Environment: Learning Communities Are Associated With a More Positive Learning Environment in a Multi-Institutional Medical School Study. *Acad Med*. 2016;91(9):1263-1269.
- ²⁵ American Medical Association. *Coaching Handbook*. Deiorio NM, Hammoud M Eds. Chicago, IL. Available at <https://www.ama-assn.org/education/coaching-medical-education-faculty-handbook>. Accessed July 17, 2018.
- ²⁶ Borkan JM, George P, Tunkel AR. Curricular Transformation: The Case Against Global Change. *Acad Med*. January 30, 2018. doi: 10.1097/ACM.0000000000002147; [Epub ahead of print]
- ²⁷ Daniel M, Fleming A, Grochowski CO et al. Why Not Wait? Eight Institutions Share Their Experiences Moving United States Medical Licensing Examination Step 1 After Core Clinical Clerkships. *Acad Med*. 2017;92(11):1515-1524.
- ²⁸ American Medical Association. Turn Med Ed on its Head: Medical Education Innovation Challenge. 2016 Team Proposals. Available at <https://www.ama-assn.org/sites/default/files/media-browser/public/ace/ace-innovation-booklet.pdf>. Accessed July 17, 2018.
- ²⁹ Skochelak S, Hammoud M, Rose S et al. AMA Innovations in Medical Education Webinar Series: Implementing a Teaching Virtual EHR as a Clinical Learning Platform. Available at <https://community-files.ama-assn.org/video/authenticated/s--xHFSwze2--/v1493238514/fgpatdzvqvwmjbcgnbot.mp4>. Accessed July 18, 2018.
- ³⁰ Hawkins R, Lomis K, Cutrer W et al. AMA Innovations in Medical Education Webinar Series: Transforming Education: Leading Innovations in Health Professions Education. Available at <https://community-files.ama-assn.org/video/authenticated/s--XPQSo5Al--/v1496859963/dqyktop5iqc4gxwgfzr.mp4>. Accessed July 18, 2018.
- ³¹ Hawkins R, Triola M. AMA Innovations in Medical Education Webinar Series: Using Big Data to Teach Population Health. Available at <https://community-files.ama-assn.org/video/authenticated/s--naBzHfqN--/v1503409013/wb2pwyw1j6ok70kkvum7.mp4>. Accessed July 18, 2018.
- ³² Hawkins R, Starr SR, Gonzalo JD, et al. AMA Innovations in Medical Education Webinar Series: Health Systems Science: The Third Pillar of Medical Education. Available at <https://community-files.ama-assn.org/video/authenticated/s--8LJZLlov--/v1508861216/o3cwo0yepbqyyzmczqle.mp4>. Accessed July 18, 2018.
- ³³ Hammoud MM, Caverzagie KJ, VanEck RN et al. AMA Innovations in Medical Education Webinar Series: Interprofessional Education: Using Technology to Teach Team-Based Care. Available at <https://community-files.ama-assn.org/video/authenticated/s--j4OXy2Ff--/v1517337718/lmebgj4kbum9m78rdczv.mp4>. Accessed July 18, 2018.
- ³⁴ Hammoud MM, Wolanskyj-Spinner AP, Ey S et al. AMA Innovations in Medical Education Webinar Series: Medical Student Wellness and Beyond: Creating a Healthy Culture for All. Available at <https://community-files.ama-assn.org/video/authenticated/s--Q9VL0TuZ--/v1521561769/nktndqjfabpwes2ngzrj.mp4>. Accessed July 18, 2018.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 7-I-18

Subject: 50th Anniversary of the AMA Physician's Recognition Award and Credit System

Presented by: Carol Berkowitz, MD, Chair

INTRODUCTION

The American Medical Association (AMA) is celebrating the 50th anniversary of the AMA Physician's Recognition Award (PRA) this year. This report regarding the AMA PRA, and the credit system that was developed to support this award, is submitted to the House of Delegates (HOD) for informational purposes.

The AMA has played a central role in the development of continuing medical education (CME) in the United States by developing the AMA PRA credit system, which codified the requirements and standards for earning *AMA PRA Category 1 Credit*[™] and *AMA PRA Category 2 Credit*[™]. The AMA PRA was established by the HOD in December 1968 to recognize physicians who, by participating in CME activities, have demonstrated their commitment to staying current with advances in medicine. The 1968 report adopted by the HOD that established the AMA PRA included the following goals:

1. To provide recognition for the many thousands of physicians who regularly participate in CME.
2. To encourage each physician to keep up-to-date and to improve knowledge and judgment by CME.
3. To provide reassurance to the public that America's physicians are maintaining their competence by regular participation in CME.
4. To emphasize the AMA's position as a leader in CME.
5. To emphasize the importance of developing more meaningful continuing education opportunities for physicians.

STATUS OF THE AMA PRA AND CREDIT SYSTEM

AMA PRA credit is the most widely accepted CME credit used by physicians of all specialties to document CME participation for licensing boards, certification boards, hospital credentialing committees, insurance groups, and other organizations. A total of 50 U.S. jurisdictions, including 45 states, four territories, and Washington, DC, currently have CME requirements for licensure of physicians; all recognize AMA PRA credit to fulfill these requirements. Many jurisdictions accept the AMA PRA certificate or an approved AMA PRA application as documentation of meeting their CME requirements.

1 The AMA PRA credit system has continued to respond to the needs of physicians and to changes in
2 the practice of medicine. Recognizing that physicians learn in different ways and that a variety of
3 educational formats should be recognized for credit, the AMA Council on Medical Education has
4 approved new educational formats for *AMA PRA Category 1 Credit™* over the years, in addition to
5 the original formats of live certified activities and enduring materials. Subsequently approved
6 formats include Journal-Based CME (1998), Manuscript Review (2003), Test Item Writing (2003),
7 Performance Improvement CME (2004), and Internet Point-of-Care (2005). Most recently, in 2017,
8 the Council on Medical Education approved a format of “Other” for those activities that meet core
9 requirements but do not fall within one of the already existing formats.

10
11 Previous domestic credit system innovations include the following:

- 12
13 1. Permitting physicians to self-claim *AMA PRA Category 2 Credit™* for educational
14 experiences (not designated for *AMA PRA Category 1 Credit™*) that comply with the
15 AMA definition of CME and pertinent Council on Ethical and Judicial Affairs opinions;
16 and
17
- 18 2. Allowing physicians to apply directly to the AMA for *AMA PRA Category 1 Credit™* for
19 defined activities that have been recognized as worthwhile learning experiences but are not
20 certified for credit through an accredited CME provider. These include teaching at live
21 CME activities that are designated for *AMA PRA Category 1 Credit™*; publishing articles
22 in MEDLINE indexed journals; presenting a poster that is included in the published
23 abstracts for a conference certified for *AMA PRA Category 1 Credit™*; earning medically-
24 related advanced degrees; completing an American Board of Medical Specialties (ABMS)
25 member board certification process (a primary ABMS member board
26 certification/recertification or a subspecialty board certification/ recertification); or
27 successfully completing an Accreditation Council for Graduate Medical Education-
28 accredited residency or fellowship.
29

30 The AMA PRA credit system also operates beyond U.S. borders. In 1990, the HOD adopted a
31 Council on Medical Education report to establish a process for qualified international conferences
32 to offer *AMA PRA Category 1 Credit™* to attendees. The International Conference Recognition
33 Program continues to this day, and international opportunities to earn *AMA PRA Category 1*
34 *Credit™* have expanded to include activities covered by agreements between the AMA and credit
35 systems of other regions and nations. Three agreements currently exist, with the European Union of
36 Medical Specialists, the Royal College of Physicians and Surgeons of Canada, and the Qatar
37 Council for Healthcare Practitioners.
38

39 Finally, the AMA has embarked upon an ongoing process with the Accreditation Council for
40 Continuing Medical Education (ACCME) with the intent of aligning the credit and accreditation
41 systems and simplifying the process for both physicians and CME providers. Organizations that are
42 accredited by either the ACCME or an ACCME-recognized state medical society are given the
43 privilege, by the AMA, of certifying activities for *AMA PRA Category 1 Credit™* and awarding
44 that credit to physicians. That privilege may be withdrawn by the AMA if the accredited CME
45 provider fails to bring the program and activities into compliance with AMA PRA policies,
46 regardless of accreditation status. Recently, the AMA developed a process with the ACCME to
47 revise requirements for accredited CME providers. That process led to development of aligned and
48 simplified requirements that became effective September 29, 2017. The AMA and the ACCME
49 will continue to work together to modernize and evolve CME activities while maintaining
50 educational quality.

1 CURRENT AMA POLICY

2
3 AMA policies related to this topic are listed in the Appendix.

4
5 SUMMARY

6
7 The past 50 years have seen many changes in CME, and the AMA has led many of these changes
8 by adapting the AMA PRA and the credit system to include new concepts, introduce new ideas,
9 and recognize the multiple ways in which physicians learn and improve. The AMA PRA credit
10 system must continue to be responsive to the needs of physicians to ensure they are adequately
11 recognized for their participation in certified CME activities. To achieve this goal, the Council on
12 Medical Education recognizes the importance of its continued stewardship of this valuable process.

13
14 As the AMA celebrates the 50th anniversary of this award, the Council on Medical Education
15 would like to draw attention to Policy H-300.959, "Physician Participation in the AMA Physician's
16 Recognition Award," which states that: "(1) the AMA, state medical societies, and specialty
17 societies in the AMA House of Delegates publicize and promote physician participation in the
18 AMA Physician's Recognition Award; and (2) that all physicians participate in the AMA
19 Physician's Recognition Award as a visible demonstration of their commitment to continuing
20 medical education." (CME Rep. 1, I-93; Reaffirmed with change in title: CME Rep. 2, A-05;
21 Reaffirmed: CME Rep. 1, A-15)

APPENDIX: RELEVANT AMA POLICY

H-275.917, “An Update on Maintenance of Licensure”

3. Our AMA will: A. Continue to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for continuing medical education in the United States, including the Performance Improvement CME (PICME) format, and continue to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME as part of the process for MOL.

H-275.924, “Maintenance of Certification”

AMA Principles on Maintenance of Certification (MOC): 10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the United States, including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

H-295.926, “Support for Development of Continuing Education Programs for Primary Care Physicians in Non-Academic Settings”

The AMA: (1) supports development, where appropriate, of programs of education for medical students and faculty in non-academic settings, making use of telecommunications as needed; (2) encourages that medical schools provide faculty development programs that are designated for *AMA PRA Category 1 Credit™*; and (3) encourages that teaching continue to be accepted for *AMA PRA Category 2 Credit™* when not designated for *AMA PRA Category 1 Credit™*.

H-300.955, “Restructuring of Continuing Medical Education Credits”

The AMA encourages state licensing boards with CME reporting requirements to allow *AMA PRA Category 1 Credit™* and *AMA PRA Category 2 Credit™* toward reregistration of the license to practice medicine; and all state licensing boards be urged to accept a current and valid AMA Physician’s Recognition Award as evidence of completion of these requirements.

H-300.959, “Physician Participation in the AMA Physician’s Recognition Award”

It is policy that: (1) the AMA, state medical societies, and specialty societies in the AMA House of Delegates publicize and promote physician participation in the AMA Physician’s Recognition Award; and (2) that all physicians participate in the AMA Physician’s Recognition Award as a visible demonstration of their commitment to continuing medical education.

H-300.974, “Unification of Continuing Education Credits”

Our AMA accepts American Academy of Family Physicians prescribed credit hours and American College of Obstetricians and Gynecologists cognate credit hours for formal learning, as equivalent to *AMA PRA Category 1 Credit™*.

H-300.977, "Revisions to the Physician's Recognition Award"

Our AMA has adopted the following changes in the Physician's Recognition Award: (1) to accept recertification by an AMA-recognized specialty board in satisfaction of requirements for a three-year PRA certificate; (2) to allow credit for international conferences when these have been approved by the AMA prior to the event; and (3) to allow credit for teaching to be reported for *AMA PRA Category 2 Credit*TM toward the award.

D-300.999, "Registration of Accredited CME Sponsors"

1. Our AMA will continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician's Recognition Award (PRA) policy when designating AMA PRA credit. 2. Our AMA will remind all accredited CME providers of their responsibility, as stated in the AMA PRA requirements, to provide documentation to participating physicians of the credit awarded at the request of the physician.

H-480.974, "Evolving Impact of Telemedicine"

Our AMA: (7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine...

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 8-I-18

Subject: Study of Medical Student, Resident, and Physician Suicide

Presented by: Carol Berkowitz, MD, Chair

1 American Medical Association (AMA) Policy D-345.984, “Study of Medical Student, Resident,
2 and Physician Suicide,” states:

3
4 That our American Medical Association determine the most efficient and accurate mechanism
5 to study the actual incidence of medical student, resident, and physician suicide, and report
6 back at the 2018 Interim Meeting of the House of Delegates with recommendations for action.
7

8 This policy resulted from Resolution 019-A-18, which called for our AMA to conduct a study to
9 accurately quantify the actual incidence of medical student, resident, and physician suicide.

10 Testimony on this item was unanimously supportive during the hearing of the Reference
11 Committee on Amendments to Constitution and Bylaws at the 2018 AMA Annual Meeting. In its
12 report, the reference committee noted the severity of the issue of physician suicide and the
13 significant need for attention to this problem. However, our AMA does not generally conduct
14 independent empirical research. Therefore, the Reference Committee suggested amending
15 Resolution 19-A-18 so that the AMA could determine the most efficient and accurate mechanism
16 to accurately quantify the actual incidence of medical student, resident, and physician suicide. Your
17 Reference Committee consequently recommended adoption with this amendment and a directive to
18 report back findings at the 2018 Interim Meeting of the House of Delegates (HOD).
19

20 The AMA Council on Medical Education recognizes the salience and timeliness of this topic and
21 agrees that appropriate resources should be dedicated to identify these mechanisms for study.
22 However, meaningful and constructive review of this issue, and of the work done to date by other
23 organizations, will require additional time. The Council therefore will present a report on this issue
24 at the 2019 Annual Meeting of the HOD.

REPORT OF THE SPEAKERS

Speakers' Report I-18

Subject: Recommendations for Policy Reconciliation

Presented by: Susan R. Bailey, MD, and Bruce A. Scott, MD

1 Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," calls on your Speakers to
2 "present one or more reconciliation reports for action by the House of Delegates relating to newly
3 passed policies from recent meetings that caused one or more existing policies to be redundant and/or
4 obsolete."
5

6 Your Speakers present this report to deal with policies, or portions of policies, that are no longer
7 relevant or that were affected by actions taken at the recent Annual Meeting. Suggestions on other
8 policy statements that your Speakers might address should be sent to hod@ama-assn.org for possible
9 action. Where changes to language will be made, additions are shown with underscore and deletions
10 are shown with strikethrough.
11

12 RECOMMENDED RECONCILIATIONS

13 *Obsolete references to be deleted from policies*

14
15
16 Policy G-600.031 characterizes the roles and responsibilities of delegates and alternate delegates. The
17 policy dates from 1999 and was most recently reaffirmed at the 2012 Annual Meeting. Your Speakers
18 regard it as an important policy, but it includes a reference to a program that no longer exists. That
19 clause will be deleted and a minor editorial change made.
20

21 G-600.031 Roles and Responsibilities of AMA Delegates and Alternate Delegates

- 22 (1) Members of the AMA House of Delegates serve as an important communications, policy, and
23 membership link between the AMA and grassroots physicians. The delegate/alternate
24 delegate is a key source of information on activities, programs, and policies of the AMA. The
25 delegate/alternate delegate is also a direct contact for the individual member to communicate
26 with and contribute to the formulation of AMA policy positions, the identification of
27 situations that might be addressed through policy implementation efforts, and the
28 implementation of AMA policies. Delegates and alternate delegates to the AMA are expected
29 to foster a positive and useful two-way relationship between grassroots physicians and the
30 AMA leadership. To fulfill these roles, AMA delegates and alternate delegates are expected
31 to make themselves readily accessible to individual members by providing the AMA with
32 their addresses, telephone numbers, and email addresses so that the AMA can make the
33 information accessible to individual members through the AMA Web site and through other
34 communication mechanisms.
35
36 (2) The roles and responsibilities of delegates and alternate delegates are as follows: (a) regularly
37 communicate AMA policy, information, activities, and programs to constituents so he/she
38 will be recognized as the representative of the AMA; (b) relate constituent views and

1 suggestions, particularly those related to implementation of AMA policy positions, to the
2 appropriate AMA leadership, governing body, or executive staff; (c) advocate constituent
3 views within the House of Delegates or other governance unit, including the executive staff;
4 (d) attend and report highlights of House of Delegates meetings to constituents, for example,
5 at hospital medical staff, county, state, and specialty society meetings; (e) serve as an
6 advocate for patients to improve the health of the public and the health care system; (f)
7 cultivate promising leaders for all levels of organized medicine and help them gain leadership
8 positions; and (g) actively recruit new AMA members and help retain current members; ~~and~~
9 ~~(h) participate in the AMA Membership Outreach Program.~~

10
11 *Directives to be rescinded in full*

12
13 The following directives will be rescinded in full, as the requested studies have been completed and
14 presented to the House of Delegates.

15
16 At the 2017 Annual Meeting, the House adopted Policy D-215.987, "Studying Healthcare Institutions
17 that Provide Child Care Services," directing our AMA to work with relevant entities to study
18 healthcare institutions to determine whether they provide childcare services and report on those
19 findings at the 2018 Annual Meeting. Board of Trustees Report 32-A-18, "Studying Healthcare
20 Institutions that Provide Child Care Services," was presented to the House as an informational report
21 and was filed. Consequently, the policy will be rescinded.

22
23 D-215.987, "Studying Healthcare Institutions that Provide Child Care Services"

- 24 1. Our AMA will work with relevant entities to study healthcare institutions to determine
25 whether they provide childcare services. Survey elements should include the size of the
26 institutions in terms of the number of physicians, physicians-in-training, and medical
27 students, how these services are organized, and the various funding mechanisms.
28 2. Our AMA will report back to the House of Delegates at the 2018 Annual Meeting the results
29 of its study on models used to provide childcare services, how these services are organized,
30 and the various funding mechanisms. This report, which is presented for the information of
31 the House, provides background on child care services in health care and the implications of
32 access to child care for physicians, as well as results of a study conducted by the AMA and
33 other relevant research.

34
35 Policy D-315.976, "Ownership of Patient Data," calling for a study on the use of patient information
36 by hospitals, was adopted at the 2017 Annual Meeting. The requested study was fulfilled by Board of
37 Trustees Report 21-A-18, "Ownership of Patient Data," an informational report that noted our AMA's
38 active engagement with the Department of Health and Human Services, the Office of the Inspector
39 General and the Office of the National Coordinator based on policies covering all aspects of patient
40 record maintenance, access and control. The policy will be rescinded.

41
42 D-315.976, "Ownership of Patient Data"

43 Our AMA will undertake a study of the use and misuse of patient information by hospitals,
44 corporations, insurance companies, or big pharma, including the impact on patient safety, quality
45 of care, and access to care when a patient's data is withheld from his or her physician, with report
46 back at the 2018 Annual Meeting.

47
48 Also adopted at the 2017 Annual Meeting was Policy D-405.982, "Management of Physician and
49 Medical Student Stress," which requested a report on various regulatory burdens placed on
50 physicians. Your Board of Trustees presented an informational report, BOT Report 36-A-18,

1 “Management of Physician and Medical Student Stress” that fulfilled the request. Therefore the
2 directive will be rescinded.

3
4 D-405.982, “Management of Physician and Medical Student Stress

5 Our AMA will produce a report on administrative and regulatory burdens placed on physicians,
6 residents and fellows, and medical students, and pursue strategies to reduce these burdens.

7
8 CHANGES IN TERMINOLOGY

9
10 The following policy statements were updated to comport with AMA style and usage in references to
11 continuing medical education credit for the AMA Physician’s Recognition Award. PolicyFinder now
12 employs an italic typeface and the trademark (™) symbol in references to *AMA PRA Category 1*
13 *Credit™* or *AMA PRA Category 2 Credit™*. The prior version of PolicyFinder did not allow these
14 features. We point this out primarily to alert members of the House to the correct usage. It also
15 happens that this year is the 50th Anniversary of the AMA Physician’s Recognition Award and Credit
16 System.

17
18 The affected policies are:

- 19 • H-275.924, “Maintenance of Certification”
20 • H-295.926, “Support for Development of Continuing Education Programs for Primary Care
21 Physicians in Non-Academic Settings”
22 • H-300.955, “Restructuring of Continuing Medical Education Credits”
23 • H-300.974, “Unification of Continuing Education Credits”
24 • H-300.977, “Revisions to the Physician's Recognition Award”
25

26 The changes outlined above do not reset the sunset clock and will be implemented when this report is
27 filed.