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MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

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

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

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

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

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

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

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

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 Numbers are deleted and not reused when policies are rescinded.

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

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

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

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

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

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

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

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<tr>
<th>Category Code</th>
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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. 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 (Info. Report)

12. Report(s) of the Council on Long Range Planning and Development - Alfred Herzog, MD, Chair
   01 Women Physicians Section Five-Year Review (F)

13. 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)
   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)

14. 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)
   04 The Site-of-Service Differential (J)

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

16. Resolutions
   001 Support of a National Registry for Advance Directives (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)
   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)
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)
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)

17. Resolutions not for consideration
   601 Creation of an AMA Election Reform Committee (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)
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.
2018 INTERIM MEETING

REFERENCE COMMITTEE HEARING LOCATIONS

SUNDAY, NOVEMBER 11
8:30 am-Noon

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<thead>
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<tr>
<td>Reference Committee B (legislation)</td>
<td>Potomac B</td>
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<tr>
<td>Reference Committee C (medical education)</td>
<td>National Harbor 10-11</td>
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<td>Reference Committee F (AMA governance and finance)</td>
<td>Maryland Ballroom</td>
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<td>Reference Committee J (medical service, medical practice, insurance)</td>
<td>Potomac C</td>
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<tr>
<td>Reference Committee K (science and public health)</td>
<td>Potomac D</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>State</th>
<th>Delegates</th>
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SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

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<td>American Academy of Child and Adolescent Psychiatry</td>
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<td>The Endocrine Society</td>
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<tr>
<td>United States and Canadian Academy of Pathology</td>
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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            Susan R. Bailey, MD            Russell W.H. Kridel, MD
President                            Speaker, House of Delegates    Secretary
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); Patricie 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. Rosenu, 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 (AMAPC 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; Ashlin 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

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

Regional Medical Student Alternate Delegate(s)
Sanjay Menghani, Vineland NJ

Arkansas Medical Society
Delegate(s)
Omar Atiq, Little Rock AR

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

Delegate(s)
Madelyn E. Butler, Tampa FL
Ronald Frederic Giffel, 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)
Charlotte K George, Tallahassee FL
Tanya Singh, Orlando FL

Medical Association of Georgia

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

Alternate Delegate(s)
John S. Antalis, Dalton GA
Jack Chapman, Gainesville GA
John Goldman, Atlanta GA

Alternate Delegate(s)
Ali Rahimi, Atlanta GA
Gary Richter, Atlanta GA

Resident and Fellow Sectional Alternate Delegate(s)
Kunj Patel, Atlanta GA

Guam Medical Society

Delegate(s)
Insaf Ally, Tamuning GU

Alternate Delegate(s)
John S. Maddox, Santa Rita GU

Hawaii Medical Association

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

Alternate Delegate(s)
Christopher Flanders, Honolulu HI

Idaho Medical Association

Delegate(s)
A. Patrice Burgess, Boise ID

Alternate Delegate(s)
Keith Davis, Shoshone ID

Illinois State Medical Society

Delegate(s)
Aadil Ahmed, Forest Park IL
Thomas M. Anderson, Chicago IL
Craig Alvin Backs, Springfield IL
James Bull, Silvis IL
Howard Chodash, Springfield IL
Peter E. Eupierre, Melrose Park IL
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 Bishop, 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 Dunniiway, Indianapolis IN
Brent Mohr, South Bend IN
Rhonda Sharp, Lagrange IN
Thomas Vidic, Elkhart IN

Resident and Fellow Sectional Delegate(s)
Colin Murphy, Seattle WA

Regional Medical Student Alternate Delegate(s)
Arvind Haran, Indianapolis IN
Giovanni Rodriguez, Indianapolis IN

Iowa Medical Society

Delegate(s)
Michael Kitchell, Ames IA
Robert Lee, Johnston IA
Victoria Sharp, Iowa City IA

Alternate Delegate(s)
Jeffrey Anderson, Johnston IA

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

Alternate Delegate(s)
Charles F. Pattavina, Bangor ME
Robert Schlagcr, Pittsfield ME

MedChi: The Maryland State Medical Society

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

Alternate Delegate(s)
Renee Bovelle, Silver Springs MD
Brooke M. Buckley, Annapolis MD
Keshav Khanijow, Baltimore MD
Gary Pushkin, Baltimore MD
Padmini Ranasinghe, Baltimore MD

Regional Medical Student Delegate(s)
Pauline P. Huynh, Baltimore MD

Massachusetts Medical Society

Delegate(s)
Maryanne C. Bombaugh, Falmouth MA
Theodore A. Calianos, Mashpee MA
Alain A. Chaouli, Boxford MA
Alice Coombs-Tolbert, Richmond VA
Ronald Dunlap, Norwell MA
Melody J. Eckardt, Milton MA
McKinley Glover, Boston MA
Francis P. Mac Millan, North Andover MA
Lee S. Perrin, Southborough MA
Richard Pieters, Duxbury MA
David A. Rosman, Jamaica Plain MA
Thomas E. Sullivan, Beverly MA
Lynda M. Young, Worcester MA

Alternate Delegate(s)
Carole Allen, Arlington MA
Nicolas Argy, Dover MA
Dennis Dimitri, Worcester MA
Henry Dorkin, Auburndale MA
Christopher Garofalo, N Attleboro MA
Kathryn Hughes, Falmouth MA
Akshay Kapoor, Worcester MA
Matthew Lecuyer, Providence RI

Massachusetts Medical Society

Alternate Delegate(s)
Michael Medlock, Lexington MA
Kenath Shamir, Fall River MA
Spiro Spanakis, Shrewsbury MA
Ellana Stinson, Quincy MA

Resident and Fellow Sectional Delegate(s)
Scott Pasichow, Warwick RI

Regional Medical Student Delegate(s)
Danny Vazquez, Boston MA

Regional Medical Student Alternate Delegate(s)
Rohan Rastogi, Boston MA
Andrew Vallejo, Boston MA

Michigan State Medical Society

Delegate(s)
Mohammed A. Arsiwala, Livonia MI
Michael D. Chafty, Kalamazoo MI
Betty S. Chu, Bloomfield Hills MI
Pino D. Colone, Howell MI
Sarah A Gorgis, Sterling Heights MI
James D. Grant, Bloomfield Hills MI
Mark C. Komorowski, Bay City MI
Bassam H. Nasr, Port Huron MI
Michael A. Sandler, West Bloomfield MI
Krishna K. Sawhney, Bloomfield Hills MI
Richard E. Smith, Detroit MI
David T. Walsworth, East Lansing MI

Alternate Delegate(s)
John G. Bizon, Battle Creek MI
Paul D. Bozyk, Beverly Hills MI
T. Jann Caison-Sokey, Bloomfield Heights MI
Jayne E. Courts, Caledonia MI
Amit Ghose, Lansing MI
Nabiha Hashmi, Troy MI
Christie L. Morgan, Grosse Pointe Woods MI
Rose M. Ramirez, Belmont MI
Venkat K. Rao, Flint MI
John A. Waters, Flint MI

Regional Medical Student Delegate(s)
Nonie Arora, Ann Arbor MI

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

**Delegate(s)**
- John Abenstein, Oronoco MN
- David L. Estrin, Plymouth MN
- David D. Luehr, Barnum MN
- Paul C. Matson, Mankato MN
- Cindy F. Smith, Willmar MN

**Alternate Delegate(s)**
- Andrea Hillerud, Saint Paul MN
- Kathryn Lombardo, Rochester MN
- David Thorson, Mahtomedi MN
- Douglas L. Wood, Rochester MN

**Resident and Fellow Sectional Alternate Delegate(s)**
- Courtney Moors, Rochester MN

### Mississippi State Medical Association

**Delegate(s)**
- Claude D. Brunson, Ridgeland MS
- Jennifer Bryan, Flowood MS
- J. Clay Hays, Jackson MS

**Alternate Delegate(s)**
- Sharon Douglas, Madison MS
- Daniel P. Edney, Vicksburg MS
- Lee Voulters, Gulfport MS

**Regional Medical Student Delegate(s)**
- William Ross, Flowood MS

### Mississippi State Medical Association

**Delegate(s)**
- Elie Azrak, St. Louis MO
- Edmond Cabbabe, St Louis MO
- James Conant, St. Joseph MO
- Rebecca Hierholzer, Leawood KS
- Warren Lovinger, Nevada MO

**Alternate Delegate(s)**
- Joseph Corrado, Mexico MO
- Ravi S Johar, Maryland Heights MO
- Michael L. O'Dell, Kansas City MO
- Shannon Tai, Lisle IL
- Charles W. Van Way, Fairway KS

**Regional Medical Student Alternate Delegate(s)**
- Manna M Varghese, Kansas City MO

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*This list does not reflect temporary changes for this meeting.*
Medical Society of New Jersey

Alternate Delegate(s)
Nancy L. Mueller, Englewood Cliffs NJ
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

New Mexico Medical Society

Delegate(s)
Steven Kanig, Albuquerque NM
Stephen P. Lucero, Taos NM

Alternate Delegate(s)
William Ritchie, Albuquerque NM
Sandra Lynn Whisler, Albuquerque NM

Medical Society of the State of New York

Delegate(s)
Jerome C. Cohen, Loch Sheldrake NY
Joshua M. Cohen, New York NY
Frank G. Dowling, Islandia NY
Moustafa Elsheshtawy, Brooklyn NY
Kira Geraci-Ciardullo, Harrison NY
Robert B. Goldberg, Morristown NJ
Howard Huang, Watertown NY
John J. Kennedy, Schenectady NY
Andrew Y. Kleinman, Rye Brook NY
Daniel J. Koretz, Ontario NY
Bonnie L. Litvack, Mont Kisco NY
Thomas J. Madejski, Medina NY
Joseph R. Maldonado, Westernville NY
Leah S. Mc Cormack, Middletown NJ
Gregory L. Pinto, Saratoga Springs NY
Malcolm D. Reid, New York NY
Charles Roithberg, Patchogue NY
Joseph Sellers, Cobleskill NY
Corliss Varnum, Oswego NY

Alternate Delegate(s)
Mark Adams, Fairport NY
Rose Berkun, Buffalo NY
Breyen Coffin, Bronx NY

Medical Society of the State of New York

Alternate Delegate(s)
Robert A. Frankel, Hewlett NY
David Jakubowicz, Scarsdale NY
William R. Latreille, Malone NY
Parag Mehta, New Hyde Park NY
John A. Ostuni, Massapequa NY
Barry Rabin, Syracuse NY
Abdul Rehman, Staten Island NY
Richard Vienne, Buffalo NY

Resident and Fellow Sectional Delegate(s)
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)
William E. Bowman, Greensboro NC
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

Alternate Delegate(s)
Timothy M. Beittel, Fayetteville NC
G Hadley Callaway, Raleigh NC
Liana Puscas, Durham NC

Resident and Fellow Sectional Delegate(s)
Jason Hall, Durham NC

Regional Medical Student Delegate(s)
Lauren Benning, Litchfield 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)
  Anthony Armstrong, Sylvania OH
  Tyler J. Campbell, Winchester OH
  Robyn F. Chatman, Cincinnati OH
  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
Alternate Delegate(s)
  Brett Coldiron, Cincinnati OH
  Shawn Cuevas, Columbus OH
  Deepak Kumar, Dayton OH
  Julie Lin, Rootstown OH
  Regina Whitfield-Kekessi, West Chester OH

Resident and Fellow Sectional Delegate(s)
  Tani Malhotra, York PA

Regional Medical Student Delegate(s)
  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
Delegate(s)
  Robert Dannenhoffer, Roseburg OR
  Sylvia Ann Emory, Eugene OR
Alternate Delegate(s)
  Peter A. Bernardo, Salem OR
  Mary McCarthy, Portland OR

Pennsylvania Medical Society
Delegate(s)
  Theodore A. Christopher, Maple Glen PA
  Michael A. DellaVecchia, Berwyn PA
  James A. Goodyear, North Wales PA
  Virginia E. Hall, Hummelstown PA
  Marilyn J. Heine, Dresher PA
  Daniel B. Kimball, Wyomissing PA
  Peter S. Lund, Fairview PA
  Anthony M. Padula, Philadelphia PA
  Judith R. Pryblick, 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)
  Erick Bergquist, Latrobe PA
  Stephen N. Clay, Philadelphia PA
  Mark Friedlander, Nabeth PA
  Kevin Owen Garrett, Allison Park PA
  Aaron E. George, Chambersburg PA
  Bruce A. Mac Leod, Pittsburgh PA
  Jill M. Owens, Bradford PA
  Evan Pollack, Bryn Mawr PA
  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.
<table>
<thead>
<tr>
<th>Medical Association</th>
<th>Delegate(s)</th>
<th>Alternate Delegate(s)</th>
</tr>
</thead>
</table>
| **Pennsylvania Medical Society**          | Regional Medical Student Delegate(s)  
Nichole Ogojiaku, Marietta GA  
Regional Medical Student Alternate Delegate(s)  
Daniel Kim, Harrisburg PA | Puerto Rico Medical Association  
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 |
| **Puerto Rico Medical Association**       | 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 | Rhode Island Medical Society  
Delegate(s)  
Alyn L. Adrain, Providence RI  
Peter A. Hollmann, Cranston RI  
Alternate Delegate(s)  
Sarah Fessler, Riverside RI |
| **Rhode Island Medical Society**          | Delegate(s)  
Alyn L. Adrain, Providence RI  
Peter A. Hollmann, Cranston RI  
Alternate Delegate(s)  
Sarah Fessler, Riverside RI | South Carolina Medical Association  
Delegate(s)  
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  
Alexander Ramsay, Charleston SC  
John Ropp, III, Hartsville SC  
Todd E Schlesinger, Charleston SC  
Regional Medical Student Delegate(s)  
Taylor Lucas, Greenville SC  
South Dakota State Medical Association  
Delegate(s)  
Mary Carpenter, Winner SD  
Alternate Delegate(s)  
Robert L. Allison, Pierre SD | Texas Medical Association  
Delegate(s)  
Susan R. Bailey, Fort Worth TX  
Michelle A. Berger, Austin TX  
Brad G. Butler, Abilene TX  
Diana Fite, Magnolia TX  
David C. Fieger, 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)  
Gerald Ray Callas, Beaumont TX  
John T. Carlo, Dallas TX  
Robert H. Emmick, Austin TX  
John G. Flores, Little Elm TX  
Gregory M. Fuller, Keller TX  
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)
M. Theresa Phan, Austin TX
Jennifer Rushton, Austin TX
Elizabeth Torres, Sugar Land TX
Roxanne Tyroch, El Pasco TX
Arlo F. Weltge, Bellaire TX
Sherif Z. Zaafran, Houston TX

Resident and Fellow Sectional Alternate Delegate(s)
Michael Metzner, San Antonio TX

Regional Medical Student Delegate(s)
Luis Seija, Temple TX

Regional Medical Student Alternate Delegate(s)
Sinan Ali Bana, Sugar Land TX
Robert Kotaki, McAllen TX
Aaron J Wolbrueck, Fort Worth TX

Utah Medical Association
Delegate(s)
Mark Bair, Highland UT
Patrice Hirning, Salt Lake City UT

Alternate Delegate(s)
Kerry Fisher, Salt Lake City UT
Richard Labasky, Sandy UT

Vermont Medical Society
Delegate(s)
Robert Block, Bennington VT

Alternate Delegate(s)
Norman Ward, Burlington VT

Medical Society of Virginia
Delegate(s)
Claudette E. Dalton, Earlysville VA
David A. Ellington, Lexington VA
Randolph J. Gould, Norfolk VA
Edward G. Koch, McLean VA
Hazle S. Konerding, Richmond VA
Mitchell B. Miller, Virginia Beach VA
Lawrence K. Monahan, Roanoke VA

Alternate Delegate(s)
Joel Thomas Bundy, Norfolk VA
Clifford L. Deal, Henrico VA

Medical Society of Virginia
Alternate Delegate(s)
Thomas W. Eppes, Forest VA
Bhushan H. Pandya, Danville VA
Sterling N. Ransone, Deltaville VA
William Reha, Woodridge VA
Cynthia C. Romero, Virginia Beach VA

Regional Medical Student Delegate(s)
Ryan Schlobach, Norfolk VA

Regional Medical Student Alternate Delegate(s)
Abby Winn, Roanoke VA

Washington State Medical Association
Delegate(s)
Erin Harnish, Longview WA
L Elizabeth Peterson, Spokane WA
Sheila D. Rege, Pasco WA
Rodney Trytko, Spokane WA

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

West Virginia State Medical Association
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)
Barbara Hummel, Greenfield WI
George Melvin Lange, Milwaukee WI
Michael M. Miller, Madison WI
Charles J. Rainey, River Hills WI
Paul A. Wertsch, Madison WI

Alternate Delegate(s)
Nameeta Dookeran, Pawaukee WI
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)
  Keshni Ramnanan, Summit WI

Resident and Fellow Sectional Delegate(s)
  Benjamin Meyer, Milwaukee WI

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

Regional Medical Student Alternate Delegate(s)
  Nathan J Carptenter, Milwaukee WI

Wyoming Medical Society

Delegate(s)
  Stephen Brown, Casper WY

Alternate Delegate(s)
  Paul Johnson, Cheyenne WY

This list does not reflect temporary changes for this meeting.
<table>
<thead>
<tr>
<th><strong>Academy of Physicians in Clinical Research</strong></th>
<th><strong>American Academy of Dermatology</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegate(s)</td>
<td>Alternate Delegate(s)</td>
</tr>
<tr>
<td>Peter Howard Rheinstein, Severna Park MD</td>
<td>Seemal Desai, Frisco TX</td>
</tr>
<tr>
<td><strong>Alternate Delegate(s)</strong></td>
<td>Adam Rubin, Philadelphia PA</td>
</tr>
<tr>
<td>Samuel Lin, Alexandria VA</td>
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<tr>
<th><strong>Aerospace Medical Association</strong></th>
<th><strong>American Academy of Facial Plastic and Reconstructive Surgery</strong></th>
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<tr>
<td>Delegate(s)</td>
<td>Delegate(s)</td>
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<tr>
<td>Hernando J. Ortega, San Antonio TX</td>
<td>J Regan Thomas, Chicago IL</td>
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<tr>
<th><strong>Air Force</strong></th>
<th><strong>Alternate Delegate(s)</strong></th>
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<tr>
<td>Delegate(s)</td>
<td>Paul Carniol, Summit NJ</td>
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<tr>
<td>Paul Friedrichs, Saint Louis MO</td>
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<tr>
<th><strong>AMDA-The Society for Post-Acute and Long-Term Care Medicine</strong></th>
<th><strong>American Academy of Family Physicians</strong></th>
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<tbody>
<tr>
<td>Delegate(s)</td>
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<tr>
<td>Eric Tangalos, Rochester MN</td>
<td>Jerry P. Abraham, Los Angeles CA</td>
</tr>
<tr>
<td><strong>Alternate Delegate(s)</strong></td>
<td>Joanna T. Bisgrove, Fitchburg WI</td>
</tr>
<tr>
<td>George Green, Abington PA</td>
<td>John Cullen, Valdez AK</td>
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<tr>
<th><strong>American Academy of Allergy, Asthma &amp; Immunology</strong></th>
<th><strong>Delegate(s)</strong></th>
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<tr>
<td>Delegate(s)</td>
<td>Elana Curry, Columbus OH</td>
</tr>
<tr>
<td>Steven G. Tolber, Corrales NM</td>
<td>Kellen Gower, St Petersburg FL</td>
</tr>
<tr>
<td><strong>Alternate Delegate(s)</strong></td>
<td>Michael Hanak, Chicago IL</td>
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<tr>
<td>George Green, Abington PA</td>
<td>Daniel Heinemann, Canton SD</td>
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<th><strong>American Academy of Child and Adolescent Psychiatry</strong></th>
<th><strong>Delegate(s)</strong></th>
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<tr>
<td>Delegate(s)</td>
<td>Kaci Larsen, Columbia MO</td>
</tr>
<tr>
<td>David Fassler, Burlington VT</td>
<td>Evelyn Lynnette Lewis &amp; Clark, Newman GA</td>
</tr>
<tr>
<td>Louis Kraus, Chicago IL</td>
<td>Glenn Loomis, Hopewell Junction NY</td>
</tr>
<tr>
<td><strong>Alternate Delegate(s)</strong></td>
<td>Michael L. Munger, Overland Park KS</td>
</tr>
<tr>
<td>Sharon L. Hirsch, Chicago IL</td>
<td>Anita Ravi, New York NY</td>
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<td>Stephen Richards, Spirit Lakes IA</td>
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<tr>
<th><strong>American Academy of Cosmetic Surgery</strong></th>
<th><strong>Delegate(s)</strong></th>
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<tbody>
<tr>
<td>Delegate(s)</td>
<td>Lawrence Rues, Leawood KS</td>
</tr>
<tr>
<td>Anthony J. Geroulis, Northfield IL</td>
<td>Hugh Taylor, Hamilton MA</td>
</tr>
<tr>
<td><strong>Alternate Delegate(s)</strong></td>
<td>Janet West, Pensacola FL</td>
</tr>
<tr>
<td>Robert F. Jackson, Noblesville IN</td>
<td>Colette R. Willis, Avon OH</td>
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<tr>
<th><strong>American Academy of Dermatology</strong></th>
<th><strong>Alternate Delegate(s)</strong></th>
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<tbody>
<tr>
<td>Delegate(s)</td>
<td>J. Mack Worthington, Chattanooga TN</td>
</tr>
<tr>
<td>Hillary Johnson-Jahangir, Iowa City IA</td>
<td>Douglas E. Henley, Leawood KS</td>
</tr>
<tr>
<td>Marta Jane Van Beek, Iowa City IA</td>
<td>Samuel Mathis, Galveston TX</td>
</tr>
<tr>
<td>Cyndi J. Yag-Howard, Naples FL</td>
<td>Julie K. Wood, Leawood KS</td>
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<tr>
<td><strong>Alternate Delegate(s)</strong></td>
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<tr>
<td>Lindsey Ackerman, Paradise Valley AZ</td>
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<tr>
<th><strong>American Academy of Hospice and Palliative Medicine</strong></th>
<th><strong>Delegate(s)</strong></th>
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<tbody>
<tr>
<td>Delegate(s)</td>
<td>Chad D. Kollas, Orlando FL</td>
</tr>
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<tr>
<th><strong>American Academy of Insurance Medicine</strong></th>
<th><strong>Delegate(s)</strong></th>
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<tbody>
<tr>
<td>Delegate(s)</td>
<td>Deborah Y. Smart, Gurnee IL</td>
</tr>
</tbody>
</table>

This list does not reflect temporary changes for this meeting.
American Academy of Insurance Medicine
Alternate Delegate(s)
Daniel George, Springfield MA

American Academy of Neurology
Delegate(s)
Nicholas Johnson, Salt Lake City UT
Shannon Kilgore, Palo Alto CA
Mark Milstein, New York NY
Alternate Delegate(s)
William Davison, Wilmette IL

American Academy of Ophthalmology
Delegate(s)
Kevin T. Flaherty, Wausau WI
Ravi Goel, Cherry Hill NJ
Lisa Nijm, Warrenville IL
Mildred M G. Olivier, Arlington Heights IL
Alternate Delegate(s)
David W. Parke, San Francisco CA

American Academy of Orthopaedic Surgeons
Delegate(s)
John Early, Dallas TX
Andrew W. Gurman, Altoona PA
Heidi Hullinger, Summit NJ
Casey J. Humbyrd, Baltimore MD
William R. Martin, Juneau AK
Michael Suk, Danville PA
Kimberly Jo Templeton, Leawood KS
Alternate Delegate(s)
William Shaffer, Washington DC

American Academy of Otolaryngic Allergy
Delegate(s)
Wesley Dean. VanderArk, Camp Hill PA

American Academy of Otolaryngology-Head and Neck Surgery
Delegate(s)
Craig Derkay, Norfolk VA
Douglas R. Myers, Vancouver WA

American Academy of Otolaryngology-Head and Neck Surgery
Delegate(s)
Robert Puchalski, Lugoff SC
Alternate Delegate(s)
James C. Dennen, III, Alexandria VA
Susan Dixon McCammon, Galveston TX

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

American Academy of Pediatrics
Delegate(s)
Toluwalase Ajayi, San Diego CA
Charles Barone, Ira MI
Carol Berkowitz, Rancho Palos Verdes CA
Melissa J. Garretson, Fort Worth TX
Zarah Iqbal, Gladwyne PA
Colleen Kraft, Mission Viejo CA
Samantha Rosman, Jamaica Plain MA
David T. Tayloe, Goldsboro NC

American Academy of Physical Medicine and Rehabilitation
Delegate(s)
Stuart Glassman, Concord NH
Susan L. Hubbell, Lima OH
Alternate Delegate(s)
Brittany Bickelhaupt, San Antonio TX
Carlo Milani, New York NY

American Academy of Psychiatry and the Law
Delegate(s)
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

American Association for Thoracic Surgery
Delegate(s)
Daniel M. Meyer, Dallas TX

American Association of Clinical Endocrinologists
Delegate(s)
Jonathan D. Leffert, Dallas TX
Alternate Delegate(s)
John A. Seibel, Los Ranchos NM

American Association of Clinical Urologists
Delegate(s)
Richard S. Pelman, Bellevue WA
Alternate Delegate(s)
Patrick H. McKenna, Madison WI

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

American Association of Neurological Surgeons
Delegate(s)
Kenneth S. Blumenfeld, San Jose CA
Alternate Delegate(s)
Maya A. Babu, Miami FL

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

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

American Association of Physicians of Indian Origin
Alternate Delegate(s)
Subhash Chandra, Amityville NY

American Association of Plastic Surgeons
Delegate(s)
Gregory L. Borah, New Brunswick NJ
Alternate Delegate(s)
Michele Manahan, Baltimore MD

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

American Clinical Neurophysiology Society
Delegate(s)
Marc Nuwer, Los Angeles CA
Alternate Delegate(s)
Jaime Lopez, Stanford CA

American College of Allergy, Asthma and Immunology
Delegate(s)
Alnoor A. Malick, Houston TX

American College of Cardiology
Delegate(s)
Benjamin Galper, Potomac MD
Jerry D. Kennett, Columbia MO
M Eugene Sherman, Englewood CO
Suma Thomas, Cleveland OH
L. Samuel Wann, Whitefish Bay WI
Kim Allan Williams, Chicago IL
Alternate Delegate(s)
David Winchester, Gainesville FL

American College of Chest Physicians (CHEST)
Delegate(s)
Neeraj Desai, Schaumburg IL

This list does not reflect temporary changes for this meeting.
<table>
<thead>
<tr>
<th>American College of Emergency Physicians</th>
<th>American College of Obstetricians and Gynecologists</th>
</tr>
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<tr>
<td><strong>Delegate(s)</strong></td>
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<tr>
<td>Michael D. Bishop, Bloomington IN</td>
<td>Cheryl Gibson-Fountain, Grosse Pointe MI</td>
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<tr>
<td>Brooks F. Bock, Vail CO</td>
<td>Joseph M. Heyman, West Newbury MA</td>
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<tr>
<td>Stephen Epstein, Boston MA</td>
<td>Nita Kulkarni, Flint MI</td>
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<tr>
<td>Michael J. Gerardi, Hackettstown NJ</td>
<td>Mary E. LaPlante, Broadview Heights OH</td>
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<tr>
<td>John C. Moorhead, Portland OR</td>
<td>Barbara S. Levy, Washington DC</td>
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<tr>
<td>Jennifer L. Wiler, Aurora CO</td>
<td>G. Sealy Massingill, Fort Worth TX</td>
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<tr>
<td><strong>Alternate Delegate(s)</strong></td>
<td><strong>Alternate Delegate(s)</strong></td>
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<tr>
<td>Nancy J. Auer, Mercer Island WA</td>
<td>Richard Allen, Portland OR</td>
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<tr>
<td>Erick Eiting, New York NY</td>
<td>Lisa Hollier, Houston TX</td>
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<tr>
<td>Vidor Friedman, Windermere FL</td>
<td><strong>Resident and Fellow Sectional Delegate(s)</strong></td>
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<tr>
<td>Reid Orth, Alexandria VA</td>
<td>Jessica Cho, Brooklyn NY</td>
</tr>
<tr>
<td><strong>American College of Gastroenterology</strong></td>
<td><strong>Resident and Fellow Sectional Alternate Delegate(s)</strong></td>
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<td><strong>Delegate(s)</strong></td>
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<tr>
<td>R Bruce Cameron, Chagrin Falls OH</td>
<td>Richard Wilbur, Lake Forest IL</td>
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<tr>
<td>March Seabrook, West Columbia SC</td>
<td><strong>American College of Legal Medicine</strong></td>
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<tr>
<td><strong>Delegate(s)</strong></td>
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<tr>
<td>Richard Wilbur, Lake Forest IL</td>
<td><strong>American College of Medical Genetics &amp; Genomics</strong></td>
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<td><strong>Delegate(s)</strong></td>
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<td>Reed E. Pyeritz, Philadelphia PA</td>
<td><strong>Delegate(s)</strong></td>
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<tr>
<td>Beverly Collins, E New Market MD</td>
<td>Beverly Collins, E New Market MD</td>
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<tr>
<td><strong>American College of Mohs Surgery</strong></td>
<td><strong>American College of Medical Genetics &amp; Genomics</strong></td>
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<tr>
<td>Michel McDonald, Nashville TN</td>
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<td><strong>Resident and Fellow Sectional Alternate Delegate(s)</strong></td>
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<tr>
<td>Keena Que, Brookline MA</td>
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<td>Alan Klitzke, Buffalo NY</td>
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<td><strong>American College of Obstetricians and Gynecologists</strong></td>
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<tr>
<td>Dana Block-Abraham, Baltimore MD</td>
<td><strong>Delegate(s)</strong></td>
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This list does not reflect temporary changes for this meeting.
This list does not reflect temporary changes for this meeting.
American Orthopaedic Association
Delegate(s)
Norman Chutkan, Phoenix AZ

American Orthopaedic Foot and Ankle Society
Delegate(s)
Michael S. Aronow, West Hartford CT
Alternate Delegate(s)
Christopher Chiodo, Walpole MA

American Osteopathic Association
Delegate(s)
William Sumners Mayo, Oxford MS
Alternate Delegate(s)
Ronald R. Burns, Winter Park FL

American Psychiatric Association
Delegate(s)
Jeffrey Akaka, Honolulu HI
Rebecca Brendel, Brookline MA
Kenneth M. Certa, Philadelphia PA
Jerry L. Halverson, Oconomowoc WI
Ray Hsiao, Bellevue WA
Saul M. Levin, Washington DC
Claudia L. Reardon, Madison WI
John Wernert, Louisville KY
Alternate Delegate(s)
Theresa M. Miskimen, Millstone Twp NJ
Paul O'Leary, Birmingham AL
Bruce Schwartz, Bronx NY
Ravi Navin Shah, New York NY
Harsh Trivedi, Nashville TN
Resident and Fellow Sectional Delegate(s)
Laura Halpin, Playa Del Rey CA
Resident and Fellow Sectional Alternate Delegate(s)
Laurel Bessey, Madison WI

American Rhinologic Society
Delegate(s)
Joshua M Levy, Atlanta GA
Alternate Delegate(s)
Kevin (Chris) Mc Mains, San Antonio TX

American Roentgen Ray Society
Delegate(s)
Denise Collins, Detroit MI
Alternate Delegate(s)
Anton N. Hasso, Orange CA

American Society for Aesthetic Plastic Surgery
Delegate(s)
Gary J. Price, Guilford CT

American Society for Clinical Pathology
Delegate(s)
Edmund R. Donoghue, Savannah GA
David Lewin, Charleston SC
James L. Wisecarver, Omaha NE
Alternate Delegate(s)
William G. Finn, Ann Arbor MI
Steven H. Kroft, Mequon WI
Fred Rodriguez, Jr., Metairie LA

American Society for Dermatologic Surgery
Delegate(s)
Jessica Krant, New York NY
Anthony Rossi, Jr., New York NY
Alternate Delegate(s)
Chad Prather, Baton Rouge LA

American Society for Gastrointestinal Endoscopy
Delegate(s)
Maurice A. Cerulli, Rockville Center NY
Walter G. Park, Los Altos CA
Alternate Delegate(s)
Donald A. O'Kieffe, Washington DC

American Society for Metabolic and Bariatric Surgery
Delegate(s)
Christopher Joyce, New Lenox IL
Alternate Delegate(s)
Bipan Chand, Maywood IL

American Society for Radiation Oncology
Delegate(s)
Shilpen A. Patel, Redwood CA

This list does not reflect temporary changes for this meeting.
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<th>Medical Society</th>
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<tr>
<td>American Society for Radiation Oncology</td>
<td>Shane Hopkins, Ames IA</td>
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<tr>
<td>American Society for Reconstructive Microsurgery</td>
<td>Gregory R. Evans, Orange CA</td>
<td>Lawrence J. Gottlieb, Chicago IL</td>
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<tr>
<td>American Society for Reproductive Medicine</td>
<td>Julia V. Johnson, Worcester MA</td>
<td>Eric Levens, Rockville MD</td>
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<tr>
<td>American Society for Surgery of the Hand</td>
<td>David Lichtman, Ft Worth TX</td>
<td>Robert C. Kramer, Beaumont TX</td>
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<td>American Society of Abdominal Surgeons</td>
<td>Louis F. Alfano, Wakefield MA</td>
<td>Philip E. McCarthy, Norwood MA</td>
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<td>American Society of Anesthesiologists</td>
<td>Randall M. Clark, Denver CO</td>
<td>Jennifer Bartlotti-Telesz, Temecula CA</td>
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<td>American Society of Breast Surgeons</td>
<td>Steven Chen, San Diego CA</td>
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<td>American Society of Cataract and Refractive Surgery</td>
<td>Brock Bakewell, Tucson AZ</td>
<td>Parag D. Parekh, Dubois PA</td>
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<td>American Society of Clinical Oncology</td>
<td>Edward P. Balaban, State College PA</td>
<td>Steve Y. Lee, New York NY</td>
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<td>American Society of Colon and Rectal Surgeons</td>
<td>Ronald Gagliano, Phoenix AZ</td>
<td>Kristina Novick, Rochester NY</td>
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<td>American Society of Dermatopathology</td>
<td>Melissa Piliang, Cleveland OH</td>
<td>Karl Napekoski, Naperville IL</td>
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<tr>
<td>American Society of Echocardiography</td>
<td>Kameswari Maganti, Chicago IL</td>
<td>Peter S. Rahko, Madison WI</td>
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This list does not reflect temporary changes for this meeting.
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<tr>
<td>American Society of General Surgeons</td>
<td>Albert M. Kwan, Clovis NM</td>
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<tr>
<td>American Society of Hematology</td>
<td>Chancellor Donald, Lafayette LA</td>
<td>Gamini S. Soori, Fort Myers FL</td>
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<td>Resident and Fellow Sectional Delegate(s)</td>
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<td></td>
<td>Erin Schwab, Chicago IL</td>
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<tr>
<td>American Society of Interventional Pain Physicians</td>
<td>Lee Snook, Sacramento CA</td>
<td>Sachin Jha, Tustin CA</td>
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<td>Resident and Fellow Sectional Delegate(s)</td>
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<td></td>
<td>Michael C. Lubrano, Boston MA</td>
<td>Alberto Bursian, Gainesville FL</td>
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<tr>
<td>American Society of Maxillofacial Surgeons</td>
<td>Victor L. Lewis, Chicago IL</td>
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<tr>
<td></td>
<td>Kant Lin, Charlottesville VA</td>
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<td>American Society of Neuroimaging</td>
<td>Ryan Hakimi, Greenville SC</td>
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<td>American Society of Neuroradiology</td>
<td>Jacqueline Anne Bello, New York NY</td>
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<td>Jack Farinhas, Bronx NY</td>
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<td>American Society of Ophthalmic Plastic and Reconstructive Surgery</td>
<td>John N. Harrington, Dallas TX</td>
<td>Erin Shriver, Iowa City IA</td>
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<td>American Society of Plastic Surgeons</td>
<td>C. Bob Basu, Houston TX</td>
<td>Robert J. Havlik, Mequon WI</td>
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<td>Sean Figy, Worcester MA</td>
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<td>American Society of Retina Specialists</td>
<td>Michael J. Davis, Arcadia CA</td>
<td>Joe Nezgoda, West Palm Beach FL</td>
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<td>American Society of Transplant Surgeons</td>
<td>Thomas G. Peters, Jacksonville FL</td>
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<td></td>
<td>Stuart M. Greenstein, Bronx NY</td>
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<td>American Thoracic Society</td>
<td>Ajanta Patel, Chicago IL</td>
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<td>Gibbe Parsons, Sacramento CA</td>
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<td>American Urological Association</td>
<td>Aaron Spitz, Laguna Hills CA</td>
<td>Willie Underwood, Williamsville NY</td>
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<td>Roger W. Satterthwaite, S Pasadena CA</td>
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<td>Hans C. Arora, Cleveland OH</td>
<td>Resident and Fellow Sectional Delegate(s)</td>
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<tr>
<td>AMUS The Society of Federal Health Professionals</td>
<td>John Cho, Fairfax VA</td>
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<tr>
<td>Army</td>
<td>Michael R. Nelson, Olney MD</td>
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<td>Kent Dezee, Bethesda MD</td>
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</tbody>
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*This list does not reflect temporary changes for this meeting.*
Association of University Radiologists  
**Delegate(s)**  
Stephen Chan, Closter NJ  
**Resident and Fellow Sectional Delegate(s)**  
Naiim S. Ali, Burlington VT  

College of American Pathologists  
**Delegate(s)**  
James L. Caruso, Castle Rock CO  
William V. Harrer, Haddonfield NJ  
Mark S. Synovec, Topeka KS  
**Alternate Delegate(s)**  
Jean Elizabeth Forsberg, Pineville LA  
Joseph Sanfrancesco, Indianapolis IN  
Susan Strate, Wichita Falls TX  
**Resident and Fellow Sectional Alternate Delegate(s)**  
Rebecca Obeng, Atlanta GA  

Congress of Neurological Surgeons  
**Delegate(s)**  
Ann R. Stroink, Bloomington IL  
**Alternate Delegate(s)**  
Krystal L. Tomei, Lyndhurst OH  

Endocrine Society, The  
**Delegate(s)**  
Palak U. Choksi, Ann Arbor MI  
Daniel Spratt, Portland ME  
**Alternate Delegate(s)**  
Robert Vigersky, Washington DC  

GLMA  
**Delegate(s)**  
Jeremy Toler, New Orleans LA  
**Alternate Delegate(s)**  
Desiray C. Bailey, Des Moines WA  

Heart Rhythm Society  
**Delegate(s)**  
Steve Hao, San Francisco CA  
**Alternate Delegate(s)**  
Jim Cheung, New York NY  

Infectious Diseases Society of America  
**Delegate(s)**  
Michael L. Butera, San Diego CA  
Steven W. Parker, Reno NV  
**Alternate Delegate(s)**  
Nancy Crum, Poway CA  
**Resident and Fellow Sectional Delegate(s)**  
Megan Srinivas, Chapel Hill NC  

International Academy of Independent Medical Evaluators  
**Delegate(s)**  
Douglas Martin, Sioux City IA  
**Alternate Delegate(s)**  
Marjorie Eskay-Auerbach, Tucson AZ  

International College of Surgeons-US Section  
**Delegate(s)**  
Raymond A. Dieter, Glen Ellyn IL  
**Alternate Delegate(s)**  
Wickii Vigneswaran, Maywood IL  

International Society for the Advancement of Spine Surgery  
**Delegate(s)**  
Gunnar B. Andersson, Chicago IL  
**Alternate Delegate(s)**  
Morgan P. Lorio, Nashville TN  

International Society of Hair Restoration Surgery  
**Delegate(s)**  
Carlos J. Puig, Houston TX  

National Association of Medical Examiners  
**Delegate(s)**  
J Scott. Denton, Bloomington IL  

National Medical Association  
**Delegate(s)**  
Gary Dennis, Frisco TX  

Navy  
**Delegate(s)**  
Christopher Quarles, FPO AE  
**Alternate Delegate(s)**  
Paul D. Pearigen, San Diego CA  

This list does not reflect temporary changes for this meeting.
North American Neuromodulation Society
Delegate(s)  
Nameer R. Haider, New Hartford NY  
Alternate Delegate(s)  
Haroon I. Hameed, Arlington VA  

North American Neuro-Ophthalmology Society  
Delegate(s)  
Thomas R. Mizen, Chicago IL  
Alternate Delegate(s)  
Nicholas Volpe, Chicago IL  

North American Spine Society  
Delegate(s)  
R Dale Blasier, Little Rock AR  
William Mitchell, Mount Laurel NJ  

Obesity Medicine Association  
Delegate(s)  
Ethan Lazarus, Greenwood Village CO  
Alternate Delegate(s)  
Fatima Cody Stanford, Boston MA  

Radiological Society of North America  
Delegate(s)  
Michael C. Brunner, Madison WI  
Kevin C. Reilly, Elizabethtown KY  
Laura E. Traube, Templeton CA  
Alternate Delegate(s)  
Nandini (Nina) M. Meyersohn, Boston MA  
Resident and Fellow Sectional Delegate(s)  
Monica Wood, Boston MA  

Renal Physicians Association  
Delegate(s)  
Louis H. Diamond, Rockville MD  
Alternate Delegate(s)  
Rebecca Schmidt, Morgantown WV  

Society for Cardiovascular Angiography and Interventions  
Delegate(s)  
J. Jeffrey Marshall, Atlanta GA  
Alternate Delegate(s)  
Clifford Kavinsky, Chicago IL  

Society for Investigative Dermatology  
Delegate(s)  
Daniel Bennett, Madison WI  
Alternate Delegate(s)  
Erica Dommasch, Boston MA  

Society for Vascular Surgery  
Delegate(s)  
Mark D. Morasch, Billings MT  

Society of American Gastrointestinal Endoscopic Surgeons  
Delegate(s)  
Paresh Shah, New York NY  
Alternate Delegate(s)  
Eli Lerner, Jacksonville FL  

Society of Critical Care Medicine  
Delegate(s)  
Russell C. Raphaely, Wilmington DE  
Tina R. Shah, Atlanta GA  
Alternate Delegate(s)  
Diane T Gowski, Clearwater FL  

Society of Hospital Medicine  
Delegate(s)  
Steven Deitelzweig, New Orleans LA  
Brad Flansbaum, Danville PA  

Society of Interventional Radiology  
Delegate(s)  
Meridith Englelander, Albany NY  
Alternate Delegate(s)  
Terence Matalon, Philadelphia PA  
Resident and Fellow Sectional Delegate(s)  
Gunjan Malhotra, Canton MI  
Resident and Fellow Sectional Alternate Delegate(s)  
Andrew Klobuka, Pittsburgh PA  

Society of Nuclear Medicine and Molecular Imaging  
Delegate(s)  
Gary L. Dillehay, Chicago IL  

This list does not reflect temporary changes for this meeting.
Society of Nuclear Medicine and Molecular Imaging

Alternate Delegate(s)
Hazem H. Chehabi, Newport Beach CA

Society of Thoracic Surgeons

Delegate(s)
Jeffrey P. Gold, Omaha NE

Alternate Delegate(s)
David D. O'Dell, Chicago IL

Spine Intervention Society

Delegate(s)
William D. Mauck, Rochester MN

Alternate Delegate(s)
Kate Sully, Portage MI

Triological Society, The

Delegate(s)
Michael E. Hoffer, Miami FL

Undersea and Hyperbaric Medical Society

Delegate(s)
Laurie Gesell, Brookfield WI

US and Canadian Academy of Pathology

Delegate(s)
Nicole Riddle, Tampa FL
Daniel Zedek, Chapel Hill NC

Alternate Delegate(s)
Keagan H. Lee, Houston TX
Nirali M. Patel, Durham NC

Resident and Fellow Sectional Alternate Delegate(s)
Valerie Lockhart, Shreveport LA

US Public Health Service

Delegate(s)
Brian M Lewis, Silver Spring MD

Alternate Delegate(s)
Dana Thomas, Yardley PA

Veterans Affairs

Delegate(s)
Carolyn M. Clancy, Washington DC

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<th>Section</th>
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<tr>
<td>Academic Physicians Section</td>
<td>Kenneth B. Simons, Milwaukee WI</td>
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<tr>
<td>Alternate Delegate(s)</td>
<td>Alma B. Littles, Tallahassee FL</td>
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<tr>
<td>Integrated Physician Practice Section</td>
<td>Russell C. Libby, Fairfax VA</td>
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<td>Devdutta Sangvai, Durham NC</td>
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<td>International Medical Graduates Section</td>
<td>Ronit Katz, Cupertino CA</td>
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<td>Ricardo Correa, Phoenix AZ</td>
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<td>Medical Student Section</td>
<td>Joy Lee, Washington DC</td>
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<td>Alternate Delegate(s)</td>
<td>Daniel Pfeifle, Sioux Falls SD</td>
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<td>Minority Affairs Section</td>
<td>Dionne Hart, Rochester MN</td>
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<td>Siobhan Wescott, Fargo ND</td>
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<td>Organized Medical Staff Section</td>
<td>Matthew Gold, Winchester MA</td>
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<td>Alternate Delegate(s)</td>
<td>Raj B. Lal, Oakbrook IL</td>
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<tr>
<td>Resident and Fellow Section</td>
<td>Mark Kashtan, Boston MA</td>
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<td>Amar Kelkar, Peoria IL</td>
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<td>Senior Physicians Section</td>
<td>Barbara Schneidman, Seattle WA</td>
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<tr>
<td>Alternate Delegate(s)</td>
<td>Luis Tomas Sanchez, Newtonville MA</td>
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<tr>
<td>Women Physicians Section</td>
<td>Josephine Nguyen, Vernon Hills IL</td>
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<td>Alternate Delegate(s)</td>
<td>Nicole L. Plenty, Indianapolis IN</td>
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<tr>
<td>Young Physicians Section</td>
<td>Kavita Arora, Cleveland Hts OH</td>
</tr>
<tr>
<td>Alternate Delegate(s)</td>
<td>Alisha Reiss, Gettysburg OH</td>
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</table>

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EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

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

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Alexander Ding 2011-2013  Kevin C. Reilly 2003-2005
Alan C. Hartford 1989-1990  Carl A. Sirio 2010-2018
Cyril M. Hetsko 2003-2011  Steven J. Stack 2006-2014
Hillary D. Johnson 2001-2002  Jordan M. VanLare 2011-2012
Matthew C. Lawyer 2004-2005  Meredith C. Williams 2010-2011
W. J. Lewis 1979-1984
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(The following are not members of the House of Delegates, but are representatives of the following societies which are represented in the SSS.)

American Academy of Emergency Medicine ................................................................. Joseph Wood, MD, JD
American Academy of Sleep Medicine ............................................................. Patrick Strollo, MD
American Association of Endocrine Surgeons ................................................... Steven De Jong, MD
American Association of Hip and Knee Surgeons ...................................... Edward Tanner, MD
American College of Correctional Physicians ........................................ Charles Lee, MD
American College of Medical Toxicology ......................................................... Charles McKay, MD
American Contact Dermatitis Society .......................................................... Bruce Brod, MD
American Epilepsy Society .............................................................................. David M. Labiner, MD
American Society of Cytopathology ................................................................. Swati Mehrotra, MD
American Society of Nuclear Cardiology ...................................................... Saurabh Malhotra, MD
American Society of Regional Anesthesia and Pain Medicine .................... Asokumar Buvanendran, MD
Association of Academic Physiatrists ............................................................ Samuel Chu, MD
Association of Professors of Dermatology .................................................. Christopher R. Shea, MD
Korean American Medical Association ......................................................... John Yun, MD
Society of Cardiovascular Computed Tomography ........................................ Dustin Thomas, MD
Society of Gynecologic Oncologists ................................................................. Carol Brown, MD
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: Info Report

**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
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

**CMS Report(s)**
01 Prescription Drug Importation for Personal Use: Minimal
02 Air Ambulance Regulations and Payments: Minimal
04 The Site-of-Service Differential: Between $100,000 - $200,000

**Report of the Speakers**
01 Recommendations for Policy Reconciliation: Minimal
Resolution(s)

001 Support of a National Registry for Advance Directives: 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
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: Minimal
805 Prompt Pay: Minimal
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
913 Addressing the Public Health Implications of Pornography: Minimal
914 Common Sense Strategy for Tobacco Control and Harm Reduction: Modest
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
**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.

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

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**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

Resolution(s)

001 Support of a National Registry for Advance Directives
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)

INTRODUCTION

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

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

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

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

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

FIRST RESOLVE

The Board believes that the term “good faith” should be omitted from AMA policy based on the first resolve of Resolution 5. Thus, AMA policy would appropriately read as follows:
RESOLVED, That our American Medical Association strongly oppose litigation challenging the exercise of a physician’s First Amendment right to express opinions regarding medical issues.

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

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

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

SECOND RESOLVE

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

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

As it happens, though, adoption of the first resolve, with the modification suggested above (viz., deletion of the “good faith” requirement), will increase the likelihood that the Litigation Center will ultimately be able to support AAPM. In other words, the Litigation Center would find it difficult to support AAPM if it had to convince itself that the physicians in question had written or spoken in good faith. With the removal of the good faith impediment, the Litigation Center can premise its support on the general principle of protecting free speech, without a detailed analysis of the facts underlying a specific case.
The Board and the Litigation Center appreciate that AAPM has been respectful of the discretion accorded to the Litigation Center. Nevertheless, the second resolve suggests that the Litigation Center might benefit from additional encouragement from the House of Delegates. Such encouragement, in this situation, would be unnecessary and might undercut the ability of the Litigation Center to act according to its determination of how the interests of the AMA can be best served through advocacy in the courts.

RECOMMENDATION

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

1. That our American Medical Association strongly oppose litigation challenging the exercise of a physician’s First Amendment right to express opinions regarding medical issues. (New HOD Policy); and


Fiscal Note: Less than $500
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)

Whereas, Advanced Care Planning (ACP) may include but is not limited to appointing a Healthcare Power of Attorney, completing a living will, and/or completing an advance directive; and

Whereas, ACP has the central goal of ensuring that a patient’s wishes and preferences in relation to his or her healthcare decisions are respected; and

Whereas, ACP improves respecting end-of-life wishes and patient and family satisfaction while reducing family member anxiety and stress; and

Whereas, Studies suggest that ACP is cost-effective in end-of-life care; and

Whereas, ACP documentation varies by state and region and is often difficult to locate; and

Whereas, There is no central database of ACP documentation that is confidential, secure, free of charge, and readily accessible for healthcare providers; therefore be it

RESOLVED, That our American Medical Association advocate for the establishment and maintenance of a national, no-charge, confidential and secure method for the storage and 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:
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
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)

INTRODUCTION

At the 2017 Interim Meeting, the House of Delegates referred Resolution 208-I-17, “Increased Use of Body-Worn Cameras by Law Enforcement Officers,” introduced by the Medical Student Section, which asked:

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

The reference committee heard testimony largely in support of referral. Testimony emphasized the use of body-worn cameras by law enforcement officers was a matter of public health and directly related to existing American Medical Association (AMA) policy concerning the health of minorities. Others expressed concern that the issues being raised were outside of the expertise and scope of our AMA. The reference committee recommended referral in order to address all concerns raised by Resolution 218. This Board report provides background, discussion of body-worn cameras by law enforcement officers, and a recommendation.

BACKGROUND

Following a number of high-profile incidents involving deadly force used against minorities, law enforcement agencies have increasingly adopted body-worn cameras for their officers. Often affixed to the torso, body-worn cameras are small, wearable audio, video or photographic recording systems that record events in which law enforcement officers are involved. The recordings can be used to demonstrate transparency to the community, to document events and to deter inappropriate, illegal or unethical behavior by both the wearer of the camera and the public.

To date, 34 states and the District of Columbia have enacted laws governing the use of body-worn cameras by law enforcement, though not all law enforcement departments utilize cameras in the same manner. For example, some permit officers to turn off the devices under certain circumstances; others do not. In addition, a 2016 survey of large police departments nationwide found that 95 percent intended to implement or had already implemented a body camera program. According to the survey, 18 percent had fully operational programs.

The cost to law enforcement entities to implement and maintain a body camera program can be costly and is an ongoing expense. Implementing a program requires an initial capital outlay to
purchase the technology and ancillary equipment; law enforcement agencies must account for
continuing operational costs, such as training on use, data storage, software and staff and
operational costs required for reviewing the recordings, redacting as necessary, and providing
recordings to courts and the public as appropriate. In Washington, DC, for example, the city spent
over $1 million outfitting 2,800 officers and expects operating costs to top $2 million per year.3

In 2015, the U.S. Department of Justice (DOJ) Bureau of Justice Assistance (BJA) awarded
$22.5 million in grant assistance to state and local law enforcement departments as part of the
Body-Worn Camera Pilot Implementation Program. The Consolidated Appropriations Act, 2018
appropriated $22.5 million for a competitive matching grant program for purchases of body-worn
cameras for state, local and tribal law enforcement. The BJA expects to make up to 28 awards for a
three-year period, to begin on October 1, 2018. State and local funding is also available for
body-worn cameras.

DISCUSSION

Predicated on whether the AMA ought to support funding of body camera programs is the question
of whether the AMA ought to support the expanded use of body cameras and whether the devices
achieve their intended outcomes.

Policing Activity

The underlying theory in support of body-worn cameras is that both officers and members of the
community will change their behaviors for the better if their actions are being recorded. Indeed, a
large body of research suggests that people act differently when they believe they are being
watched. In the context of law enforcement, body-worn cameras are expected to increase self-
awareness and thus deter unprofessional, inappropriate and illegal behavior by officers and
civilians alike. As law enforcement officers are more likely to use force against minority
community members, many hope body-worn cameras will improve policing behavior toward
minorities, using force only when warranted and de-escalation tactics have failed.4,5 In cases where
law enforcement officers do use force, body-worn cameras offer contemporaneous evidence of the
officers’ actions so that improper behavior can be disciplined. Evidence about the impact of
cameras on policing activity generally, though not universally, supports this theory.

An early study conducted in the Rialto, California police department found use-of-force incidents
declined 58.3 percent over a three-year period after a body camera program was implemented.6
Importantly, researchers later found that use of force rates were higher in the same Rialto,
California police force despite the presence of a camera when officers were allowed discretion to
turn off cameras.7 Another randomized controlled trial conducted between 2014 and 2015 in the
Las Vegas Metropolitan Police Department found that officers wearing body cameras were
12.5 percent less likely to be involved in a use of force incident.8 Similar results were found in
Orlando, Florida.9 In contrast, the largest randomized controlled study to date, conducted in 2015
with the Metropolitan Police Department of the District of Columbia, found no statistically
significant difference in the rates of police use of force.10

Research has found mixed results about other forms of police activity. In the study conducted in
Las Vegas, body camera use was not associated with a change in the number of police-community
interactions, but body cameras were associated with a 6.8 percent increase in the number of
citations issued and a 5.2 percent increase in the number of events that resulted in an arrest. A 2015
study conducted in Mesa, Arizona found officers wearing a camera were less likely to perform
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. However, other studies have found body-worn cameras are associated with slightly lower incidents of arrest.

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.” 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. One such study conducted by the Urban Institute found that body-worn cameras do improve community members’ satisfaction with police encounters. 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.

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. 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. In Phoenix, complaints against officers who wore the cameras declined by 23 percent, compared to a 10.6 percent increase among comparison officers. 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.

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. 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.

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 disproportionally 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. 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.

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. African-American men report more anxiety and post-traumatic stress disorder and more morbidity from these psychiatric conditions than Caucasian men. 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. Research on the correlation between health and policing, however, remains sparse and warrants further research.
RELEVANT AMA POLICIES

Existing AMA policy does not address the use or funding of body-worn cameras. However, AMA policy does state that physical or verbal violence between law enforcement officers and the public, particularly within ethnic and racial minority communities, is a social determinant of health and supports research into the public health effects of violent interactions. (H-515.955) In addition, Policy H-350.971 “AMA Initiatives Regarding Minorities” instructs the AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health.

New policy adopted during the 2018 Annual Meeting encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies. New policy also encourage appropriate stakeholders, including law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.

Additionally, Policy H-145.977 “Use of Conducted Electrical Devices by Law Enforcement Agencies” cautions against excessive use of conducted electrical devices (often called Tasers) and recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training and an accountability system for the use of conducted electrical devices. AMA policy recommends research into the health impacts of conducted electrical device use and development of a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to conducted electrical devices.

RECOMMENDATION

The Board recommends that the following be adopted in lieu of Resolution 208-I-17, and that the remainder of the report be filed.

That our American Medical Association work with interested state and national medical specialty societies to support state legislation and/or regulation that would encourage the use of body-worn camera programs for law enforcement officers and fund the purchase of body-worn cameras, training for officers and technical assistance for law enforcement agencies.

Fiscal Note: Less than $5,000
REFERENCES


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_de_cop_will_soon_have_a_body_camera_heres_wha


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)

INTRODUCTION

At the 2017 Interim Meeting, the House of Delegates referred Resolution 211-I-17, “Exclusive State Control of Methadone Clinics,” introduced by the Indiana Delegation, which asked:

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

Reference committee testimony generally was mixed and noted that there is likely both a state and federal role as it relates to methadone clinic approval and operations. Delegates encouraged further study, including discussion about methadone clinic reporting to state prescription drug monitoring programs (PDMP). This report reviews existing information, provides background and presents recommendations.

DISCUSSION

Your Board strongly agrees with the authors of Resolution 211-I-17 that methadone clinics provide a valuable service to patients with an opioid use disorder. Methadone maintenance therapy (MMT) for the treatment of opioid use disorder has been used for more than 40 years to help patients, having been approved in 1972 by the U.S. Food and Drug Administration (FDA) for treatment of heroin addiction. The health and safety of methadone has been studied extensively and ample evidence exists supporting its use to aid in mortality and crime reduction.1

There are more than 1,600 certified opioid treatment programs (OTPs) offering methadone in the U.S.2 According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the number of persons receiving methadone increased by 34 percent from 2006 (258,752) to 2016 (345,443).3 With respect to opioid-related mortality, deaths attributed to methadone increased rapidly from 1999 (784 deaths) to their peak in 2007 (5,518) and have steadily declined since with 3,373 methadone-related deaths in 2016, according to the Centers for Disease Control and Prevention.4 It is beyond the scope of this report to detail whether the methadone use in these deaths was for the treatment of pain, for opioid use disorder, related to illicit use or was a complicating polypharmacy factor.

The FDA, U.S. Drug Enforcement Administration (DEA), U.S. Department of Health and Human 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](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.  

**DEA Regulatory Authority**

DEA authority with respect to methadone focuses on the medication’s classification as a Schedule II controlled substance. 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).”

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.

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.

**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
staffing requirements, employment qualifications and other personnel-related issues. These are
within the control of the state. And while it is complicated and beyond the scope of this report,
states also have a certain amount of leeway in determining zoning requirements for where an OTP
would be located. Notably, your Board strongly supports OTPs being treated no differently than
any other medical clinic that may seek to provide care in a community.10

SAMHSA also has recognized the clear need for OTPs to work with leaders in the community to
ensure comprehensive support services. That is, to support/encourage collaborative, multiagency
surveillance efforts to obtain timely and comprehensive data to target interventions and inform
prevention and response efforts. This includes working with the community to help determine
where an OTP is most needed; how an OTP can be integrated into the community with the least
impact on neighborhoods and traffic, for example; how to help educate the community on the
benefits of treatment for opioid use disorder so as to reduce stigma; and other areas.11

Another area of state control—which raises potential conflicts with federal law—concerns whether
OTPs should be required to report methadone dispensing information to the state PDMP. This issue
is extremely controversial. In fact, while this issue was raised by the resolution that gave rise to this
report, it also was raised in Resolution 507 from the 2018 Annual Meeting. Resolution 507-A-18
was referred for further study of a more extensive range of privacy and clinical issues relating to
PDMPs and OTPs. Given that your Board is currently deliberating on Resolution 507-A-18, and
the fact that SAMHSA has not specifically resolved the many issues associated with reporting OTP
information to state PDMPs,12 your Board believes it would be prudent to delay further comment
here so as not to cause confusion with pending research and discussions. Your Board does note,
however, that our AMA continues to urge physicians to use PDMPs to help inform their clinical
decision making. There is nothing to prevent physicians and other health care professionals in an
OTP from checking the state PDMP to ensure a patient is not receiving prescriptions for controlled
substances from other providers. Whether an OTP should report to a PDMP, however, is a matter
of federal—not state—jurisdiction.

Additional areas where states can help complement the medical care provided at OTPs include
promotion of take-home naloxone (governed by state law); education that helps remove the stigma
associated with MMT and medication assisted treatment (MAT); working toward policies that
remove health insurance and pharmacy benefit management company barriers to receiving MMT
and MAT (e.g., prior authorization, network adequacy for mental health care); prompt and accurate
overdose reporting for surveillance efforts related to prevention, treatment, and response;
identification of linkages within the community to peer counseling and other support services, to
name a few.

Furthermore, to complement and assist OTPs with the federal requirement to help an OTP identify
and prevent patients from enrolling in multiple OTPs concurrently, states can develop
communications and other tools to help OTPs (and other health care providers) identify all OTPs
doing business in a state and in surrounding areas. Federal rules already require an OTP to take
reasonable measures to do this. It seems reasonable that this would be an area where the state,
working with health insurance companies and other payers, as well as with the medical community,
would be well-advised to develop such a mapping/informational tool. This would not only allow
OTPs to more easily communicate with each other, but it would help patients identify where OTPs
exist in the state.

In Indiana, for example, the federal OTP locator maintained by SAMHSA identifies 16 OTPs
operating in the state,13 but it does not allow for multiple states to be displayed simultaneously. The
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)
3. That our AMA advocate for the federal agencies responsible for approving opioid treatment programs to consider the views of state and local stakeholders when making decisions about OTP locations and policies. (New HOD Policy)

Fiscal Note: $2,500
REFERENCES


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


7 42 CFR Part 8, available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=3&SID=7282616aa574225f795d5849935efe45&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=7282616aa574225f795d5849935efe45&ty=HTML&h=L&n=pt42.1.8&r=P ART#se42.1.8_12

9 42 CFR Part 8.12


REPORT OF THE BOARD OF TRUSTEES

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)

INTRODUCTION

At the 2017 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 212-A-17, submitted by the American College of Legal Medicine (ACLM). The resolution asked that our AMA:

- Join the American College of Legal Medicine to advocate federally-mandated interfaces between provider/dispenser electronic health record systems in the clinical, hospital and pharmacy environments and state prescription drug databases and/or prescription drug management plans;
- Advocate that the cost of generating these interfaces be borne by the commercial EHR and dispensing program providers;
- Advocate that the interface should include automatic query of any opioid prescription, from a provider against the state prescription drug database/prescription drug management plan (PDMP) to determine whether such a patient has received such a medication, or another Schedule II drug from any provider in the preceding ninety (90) days;
- Advocate that the prescriber and the patient’s EHR-listed dispensing pharmacy should then be notified of the existence of the referenced patient in the relevant PDMP database, the substance of the previous prescription(s) (including the medication name, number dispensed and prescriber’s directions for use) in real time and prior to the patient receiving such medication;
- Advocate that the electronic record management program at the pharmacy filling the relevant prescription, contemporaneously as it enters the filling of the prescription by the pharmacist, likewise be required to automatically query the state PDMP as a secondary mechanism to prevent inappropriate prescribing, forgery, duplication and/or too great a frequency of use of the involved controlled medication;
- Work with ACLM and other concerned societies to urge Congress to timely enact and implement such a statutory scheme supported by a workable and concise regulatory framework, chiefly concentrating on the interfacing of all applicable electronic health record and pharmaceutical dispensing systems with every individual state’s PDMP, thereafter designating a timeframe wherein all treating providers and dispensing pharmacists would be
required to perform such queries, in concert with the routine ordering of and filling of a controlled substance to be used in the treatment of patients;

Advocate that oversight of the appropriate prescribing of and filling of prescriptions for controlled substances remain with the involved individual federal and state criminal law enforcement agencies, the involved state departments of health, or similar entities and the involved relevant state provider and/or pharmacy licensure authorities; and

Advocate that statistics be maintained and reviewed on a periodic basis by state PDMP personnel and relayed to state departments of health or agencies similarly situated so as to identify and possibly treat those patients identified through this screening mechanism as potential drug abusers and/or at risk of addiction.

Board of Trustees (BOT) Report 12-A-18 summarized work that the AMA has done in support of ensuring accurate, reliable Prescription Drug Monitoring Programs (PDMPs) that support clinical decision-making. It also addressed many of the complexities raised in the original resolution, including evolution of PDMPs, and their integration with electronic health records (EHRs) and electronic prescribing of controlled substances (EPCS).

After debate, the HOD referred BOT Report 12-A-18 back for consideration. While general support existed for the recommendations contained in the report, the HOD asked for additional information on the evolution of PDMPs. This report, therefore, updates and expands upon the information in BOT Report 12-A-18 and presents amended policy recommendations.

DISCUSSION

More than 300 million queries of state PDMPs were made in 2017, more than doubling the 136 million queries in 2016, and five times the 61 million queries submitted in 2014.\(^1\) Physician adoption of EHRs also continues to grow. The Office of the National Coordinator for Health Information Technology maintains that nearly 90 percent of office-based physicians are using EHRs.\(^2\)

A major goal of AMA advocacy and many others continues to be the integration of electronic systems that can support efforts to address the opioid epidemic. To effectively support physician and public health efforts to prevent opioid overdose deaths, the AMA has urged that electronic systems be interoperable and integrated into medical practice workflows. As noted in BOT Report 12-A-18, information exchanged with EHRs is not well incorporated into the physician’s workflow. Obtaining important information, including PDMP data, often requires multiple “clicks,” opening multiple windows, and the use of separate logins even before the physician locates what he or she is looking for—and that situation must be repeated for each patient and every prescription for a controlled substance. Effective PDMP and EHR integration means that the workflow must achieve “functional interoperability,” or the ability for systems to exchange, incorporate and display data in a meaningful and contextual manner.

The Centers for Medicare & Medicaid Services highlighted this in a recent letter to state Medicaid directors, noting that when integration occurs, it “removes the requirement for providers to log in to a separate system, manage a separate log in, and disrupt their workflow to query the PDMP. Single sign-on interoperability between EHR and PDMP such that PDMP results are displayed when the EHR indicates a controlled substance is prescribed could be supported, as an example.”\(^3\)
Many consider the ideal practice to be a “one-click” solution with PDMP data and EPCS integrated into physicians’ EHR systems. On one hand, many EHR vendors are pulled in too many directions to focus on this need. Federal regulations require vendors to develop EHRs that meet administrative requirements. To achieve the ideal for PDMP and EPCS integration, more must be done to reduce the regulatory pressure on health IT development, allowing vendors the flexibility to respond to physician and patient needs, rather than spending the bulk of their time complying with administrative demands.

Yet, there have been reports of progress of successful PDMP-EHR integration. For example, the University of North Carolina (UNC) Health Care at Chapel Hill, reported that efforts to integrate its Epic EHR with the state PDMP have been positive. A news report from July found that “[i]n the first two weeks, more than 540 UNC clinicians used the PDMP when treating some 2,950 patients, which officials said has saved physicians about 119 hours already.”

Oschner Health System in New Orleans, Louisiana, also has used Epic to integrate the EHR with the state PDMP. Deaconess Health, which operates several hospitals in Indiana, also has made strides to integrate EHRs with the state PDMP. And there are many different options in the commercial market, although your Board notes that a Google search of effective PDMP-EHR integration efforts results in dozens of options.

In addition to growing physician use of PDMPs, interstate interoperability has expanded considerably. According to the National Association of Boards of Pharmacy, 44 states now can securely share PDMP information across state lines. The effects of expanded PDMP use on patient care are mostly unknown; physicians and other health care professionals are not the only ones interested in using the PDMP data.

As noted above, PDMP use among physicians and other health care professionals has significantly increased in recent years; however, opioid-related mortality continues to increase, driven principally by heroin, illicit fentanyl, and other synthetic derivatives. Moreover, as PDMP use increases and opioid prescribing rates decrease, it is not clear that PDMPs are making a significant impact on improving patients’ pain care. One review concluded that “[e]vidence that PDMP implementation either increases or decreases nonfatal or fatal overdoses is largely insufficient, as is evidence regarding positive associations between specific administrative features and successful programs. Some evidence showed unintended consequences. Research is needed to identify a set of “best practices” and complementary initiatives to address these consequences.”

There may also be a need for additional clarity on how PDMP data may be used by non-health care professionals, including health insurance companies, pharmacy benefit management companies (PBMs), and law enforcement. For example, earlier this year, the U.S. Department of Justice and 48 attorneys general reached an agreement to share data. According to the news release, “Drug Enforcement Agency DEA will provide the Attorneys General with that data, and the states will provide their own information, often from prescription drug monitoring programs (PDMPs) to DEA. Under the agreement, both state and federal law enforcement will have more information at their disposal to find the tell-tale signs of crime.” It is not clear what these “tell-tale signs” might be.

Progress has been considerably slower in achieving EPCS uptake, largely due to outdated regulations from the DEA. The combination of personal identification numbers (PINs), passwords, and biometrics required to meet DEA standards for “two-factor authentication” increase EPCS security but add to workflow disruptions and increase costs. DEA, EPCS requirements include onerous limits on use of biometric devices, which must comply with federal standards that set an unnecessarily high bar and prevent use of user-friendly consumer electronics already found in
physicians’ offices for two-factor authentication. The biometric fingerprint scanners found on these consumer devices, i.e., smart phone, tables, and laptop computers, are used for secure access to other sensitive information, like banking and medical records, but typically do not comport with rigid rules for EPCS.

The AMA views EPCS as important to support high-quality patient care. Physicians commonly report that they are frustrated that they can e-prescribe non-controlled substance medications but must still use written prescriptions for controlled substances. More than 70 percent of physicians are e-prescribing non-controlled drugs but only 20 percent used EPCS. One reason for this is due to the fact that not all EHR vendors understand or can satisfy EPCS requirements—state EPCS mandates have increased uptake, but implementation has been delayed due to questions about system certification, cost to providers, and patient concerns, i.e., transferring prescriptions between pharmacies. Moreover, EHR vendor processes for EPCS do not always align well with normal e-prescribing workflows—often physicians must start new computer programs and windows each time they use EPCS. Cumbersome workflows and applications that do not take physician needs into account impede EPCS uptake. Finally, although EPCS reduces prescription fraud and diversion, it is less clear how it affects valid prescriptions for opioid analgesics. For example, does the prescriber using EPCS put in a dose and duration or are numbers suggested by the EPCS system and, if so, how are these amounts derived? These are among the questions the AMA has been asking from vendors and physicians.

To help resolve other barriers, the AMA and the President’s Commission on Combating Drug Addiction and the Opioid Crisis have recommended the DEA modify EPCS regulations in order to reduce barriers to EPCS adoption. The AMA asked DEA to reexamine the scope of technology that is compliant with EPCS requirements and allow use of lower-cost, high-performing biometric devices in two-factor authentication. The AMA also believes that there must be further study to evaluate the variations in how EPCS systems handle initial dosing, i.e., are opioid doses or durations auto-populated in EPCS systems and, if so, are the amounts appropriate.

A final point is that the AMA has made clear to the DEA that its requirements for biometric devices limit user-friendly consumer electronics already found in physicians’ offices, such as fingerprint readers on laptop computers and mobile phones, from being utilized for two-factor authentication in EPCS. This and other rules contribute to cumbersome workflows and applications which are an impediment to physician EPCS uptake. Encouraging EPCS uptake and interoperability of PDMP databases and electronic health records would improve the integration of controlled substance use data into practice workflows and clinical decision-making.

The AMA also continues its efforts in support of making PDMPs better clinical tools. The use of PDMPs continues to increase in states regardless of mandates—tied mainly to quality of the PDMP as a decision-support tool in those states without mandates. Important policies that have improved PDMP workflow and data reliability include delegate access, data input by pharmacists within 24 hours, and states sharing PDMP information. PDMP usability continues to improve, but usage in rural and other areas may be affected by lack of access to broadband and other technologies. Consistent, long-term funding of state PDMPs is also a concern—most states depend on federal grants for ongoing maintenance and improvements. The AMA also continues to try and identify best practices in designing PDMPs to identify risk including: distinguishing between uncoordinated care, misuse, and “doctor shopping,” identifying opportunities for referrals to specialized care; providing reports to prescribers to better inform prescribing decisions; and conducting public health surveillance activities.10
One best practice is PDMP and EHR integration, but, as previously discussed, that goal remains largely elusive. It is not clear, for example, how many PDMPs are integrated into EHRs, which makes identification of best practices challenging given the variety of EHR systems in use. Each state PDMP may require a slightly different interface to connect to an EHR. With over 600 different EHRs on the market, the number of custom EHR/PDMP interfaces required can reach into the thousands. Custom software development is time-consuming and expensive—with costs being passed on to the physician. Without PDMP and EHR integration, physicians must use multiple usernames and passwords to shuttle between different systems, often having to re-enter login information if one system times out while they are using the other one. This results in increased time to enter information, decreased satisfaction with the technology, and potentially less use of the systems.

Furthermore, the AMA notes that one dominant PDMP developer is responsible for the PDMP platforms of more than 40 states. PDMP quality and uptake has improved and it is clear that the PDMP interface is moving toward greater integration through the use of more advanced tools offered by the developer. This development, along with the growing interstate interoperability has led, anecdotally, to physicians receiving a greater number of alerts about potentially dangerous drug combinations, multiple prescriber events, and other clinical issues. Yet, these advanced tools are not without costs, and it is not clear how these tools may be affecting patient care. The PDMP interface can help identify a patient’s prescription history, but that is only one component of effectively screening a patient for a potential substance use disorder or helping understand whether a patient’s pain is being effectively managed.

Similarly, while there are some positive examples with PDMP-EHR integration, EHRs are generally not interoperable between different organizations, making coordination between primary care physicians, pain medicine physicians, addiction medicine physicians and other providers much more difficult. When PDMP and EHR integration does exist (e.g., Oregon’s EDIE), the patient, public health and cost utilization benefits are extremely positive. This integration requires time and broad, institutional support. For example, the state of Washington’s integration project with the state Health Information Exchange (HIE) began in 2012. As of August 2017, more than 90 percent of emergency departments include PDMP data in the EHR using data through the HIE. The state’s major health systems still are working to accomplish this integration.

To help resolve some of these issues, the AMA advocates for consistent and sufficient appropriations to support a state’s ability to maintain and improve its PDMP, including broad state-based grants to improve statewide HIEs and the ability to integrate HIE data into the EHR of statewide emergency departments and other providers. The AMA also would support a U.S. Government Accountability Office study on best practices for small and large physician practices on using PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying how PDMPs can distinguish uncoordinated care from misuse or “doctor shopping” as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care. In addition, a need exists to evaluate the variations in state-based PDMP technology and work with the health IT industry to discuss “common understanding” of how each PDMP works—providing transparency for EHR vendors to facilitate development of custom connections between their products and PDMP software. This could include funding for programs that pilot test low-cost technologies to better integrate EHRs and PDMPs as well as efforts to identify burdensome federal regulations that prevent EHRs from being designed and developed to support objective clinical decision-making.

The AMA also has been engaged in the SMART project to help EHR systems work better for physicians and patients. A key component of this effort is the development of a flexible
information infrastructure that allows for free, open development of plug and play applications (apps) to increase interoperability among health care technologies, including EHRs, in a more cost-effective way. The infrastructure development specific to PDMPs is part of both ongoing research as well as work by states working to achieve more comprehensive data integration. In addition, the Office of the National Coordinator for Health Information Technology has compiled multiple sources and pilot examples for PDMP and EHR integration. The pilot examples, not surprisingly, found that PDMPs were most helpful when they were integrated into physicians’ workflow as well as EHRs.

AMA POLICY

The AMA House of Delegates has provided strong guidance to the AMA that reflects the issues raised by the original resolution that is the subject of this report. Relevant policies include:

Policy H-120.957, “Prescription of Schedule II Medications by Fax and Electronic Data Transmission,” which “encourages the Drug Enforcement Administration to support two factor authentication that is easier to implement than the current DEA and EPCS security requirements; and because sufficient concerns exist about privacy and confidentiality, authenticity, and other security measures, does not support the use of “hard copy” facsimile transmissions as the original written prescription for Schedule II controlled substances, except as currently allowed in Section 1306 of Title 21 of the Code of Federal Regulations.”

In addition, Policy H-95.928, “Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing,” provides that the AMA support multiple facets of PDMP development, including interoperability, assisting physicians and pharmacists in identifying “when their patients have received a prescription for controlled substances from multiple prescribers or multiple pharmacies within a short time frame.”

Policy D-478.972, “EHR Interoperability,” calls for the AMA to continue efforts in support of EHR interoperability standards, reducing excessive costs and generally reducing barriers to EHR adoption.

Finally, Policy D-478.994, “Health Information Technology,” broadly notes AMA support for “legislation and other appropriate initiatives that provide incentives for physicians to acquire health information technology,” which reasonably would include PDMP EPCS and EHR uptake.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 212-A-17, and the remainder of the report be filed:

1. That our American Medical Association (AMA) advocate for a federal study to evaluate the use of PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying whether PDMPs can distinguish team-based care from uncoordinated care, misuse, or “doctor shopping,” as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care. (Directive to Take Action)

2. That our AMA urge EHR vendors to increase transparency of custom connections and costs for physicians to integrate their products in their practice. (Directive to Take Action)
3. That our AMA support state-based pilot studies of best practices to integrate EHRs, EPCS and PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such integration from occurring. (New HOD Policy)

Fiscal Note: Less than $500
REFERENCES

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/
11 Appriss Health Gateway explained at https://apprisshealth.com/solutions/pmp-gateway/
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 uninsured 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. 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.” 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). 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. Also, hospitals must meet payer-mix criteria related to the Medicare DSH program with the exception of CAHs. 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. 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.

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. The number of hospitals has grown significantly, from 591 in 2005 to 2,479 as of October 2017.
There have also been a number of unintended consequences of the 340B program. A 2015 Avalere study found that hospitals participating in the 340B program were more likely than non-340B hospitals to acquire independent physician practices. These acquisitions create financial windfalls for hospitals due to the 340B program yet do not necessarily improve affordability for patients. Patient costs and resultant co-pays/co-insurance and deductibles for care in a hospital outpatient department (HOPDs) can be higher than those in physician offices. (In those instances, patient care in HOPDs is more costly for health insurers too.) Furthermore, some 340B eligible hospitals may have commercial contracts that pay substantially more than the Medicare rate for drugs, so the profit margin can be multiples of the cost of the drug. Patients may face a 20 percent coinsurance on this higher amount. Yet, hospitals eligible for the 340B program obtain drugs at a substantial discount. The 340B program does not require that the hospital pass the savings to uninsured or underinsured low-income patients. To the extent that the hospital does not pass along the savings, the combined payment by insurer and patient provides profit for the 340B hospital; the additional volume generated when 340B hospitals acquire independent physician practices results in even greater profits. There are also reports that hospital systems have acquired 340B program eligible hospitals in order to purchase drugs for their suburban clinics utilizing the discounts even though such clinics do not serve uninsured or underinsured low-income patients.

There have been several congressional hearings on the 340B program convened by the U.S. Senate’s Health, Education, Labor, and Pension (HELP) Committee as well as the U.S. House of Representatives’ Energy and Commerce (E&C) Committee. Testimony offered by the U.S. Government Accountability Office (GAO), the HHS Office of the Inspector General (OIG), and other witnesses included concerns with the 340B program’s: (1) inadequate “patient” definition; (2) eligibility criteria for covered entity; (3) oversight of covered entities and manufacturers; and (4) oversight of the use of contract pharmacies. The lack of program data to assess the extent to which 340B program covered entities are ensuring low-income patients benefit from the rebates and the savings has particularly troubled policymakers and other stakeholders.

In addition to the hearings, over 17 federal bills have been introduced concerning the 340B program in this Congress. A number of the bills would mandate reporting on care provided to low-income individuals and would impose new eligibility requirements for certain categories of covered entities. For example, in December 2017, Representative Larry Buschon (R-IN) introduced H.R. 4710, Protecting Access for Underserved and Safety-net Entities Act (340B PAUSE Act). The bill would impose a moratorium on registration for certain new 340B program hospitals and associated sites. H.R. 4710 would also mandate data collection by covered entities including the number and percentage of insured (by insurer) and uninsured individuals who are dispensed or administered 340B program discounted drugs. In January 2018, Senator Bill Cassidy (R-LA) introduced S. 2312, Helping Ensure Low-income Patients have Access to Care and Treatment Act (HELP Act). The bill would impose a registration moratorium on new non-rural 340B program covered entities and associated sites as well as new eligibility requirements for covered entities. It would also require reports on the level of charity care provided by covered entities. Similarly, in April 2018, Representative Earl Carter (R-GA) introduced H.R. 5598, 340B Optimization Act. The bill would amend the Public Health Service Act to require certain disproportionate share hospital covered entities under the 340B drug discount program submit to HHS reports on low-income utilization rates of outpatient hospital services furnished by such entities.

In order to address the lack of data available directly from 340B program hospital covered entities or HRSA vis-à-vis the benefit to low-income patients, the House E&C Committee Chairman Greg Walden (R-OR) and health subcommittee Chairman Michael Burgess (R-TX) requested a report on 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 programs 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)
2. Our AMA will confer with national medical specialty societies on providing policymakers with specific recommended covered entity criteria for the 340B drug discount program. (Directive 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.
3 42 U.S.C. § 256b(a)(4)(A)-(K)
4 Id.
5 Id.
6 Id.
9 Id.
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
INTRODUCTION

Resolution 419-A-18, “Violence Prevention,” was introduced by the Washington Delegation. The first and third Resolves, which were referred by the House of Delegates, asked:

That our American Medical Association (1) advocate that a valid permit be required before the sale of all rapidly-firing semi-automatic firearms and (3) study options for improving the mental health reporting systems and patient privacy laws at both the state and federal levels and how those can be modified to allow greater information sharing between state and federal government, law enforcement, schools and mental health professionals to identify, track and share information about mentally ill persons with high risk of violence and either report to law enforcement and/or the National Instant Criminal Background Check System, with appropriate protections.

Accordingly, this report addresses both firearm licensing and mental health reporting requirements.

CURRENT AMA POLICY

As one of the main causes of intentional and unintentional injuries and deaths, the American Medical Association (AMA) recognizes that firearm-related violence is a serious public health crisis in the United States. The AMA has extensive policy on firearm safety and violence prevention. Relevant to this report is existing policy that supports requiring the licensing of firearm owners, including completion of a required safety course and registration of all firearms. The AMA also supports a waiting period and background check for all firearm purchasers.

AMA also 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) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (3) requiring gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (4) efforts to ensure the public is aware of the existence of laws that allow for the 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. 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).

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.
It is important to note that a diagnosis of, or treatment for, mental illness does not alone qualify an individual for reporting to the NICS. Existing federal criteria for firearm-disqualifying mental health records are not perfect. They have been criticized for being both over-inclusive and under-inclusive. It is the American Psychiatric Association’s position that:

Reasonable restrictions on gun access are appropriate, but such restrictions should not be based solely on a diagnosis of mental disorder. Diagnostic categories vary widely in the kinds of symptoms, impairments, and disabilities found in affected individuals. Even within a given diagnosis, there is considerable heterogeneity of symptoms and impairments.

Furthermore, individuals with mental illness, when appropriately treated, do not pose an increased risk of violence compared with the general population. However, mental illness is strongly associated with suicide, which represents nearly 60 percent of firearm-related deaths in the United States.

DISCUSSION

State Licensing Requirements

Federal law does not require the licensing of firearm purchasers or owners. A number of states have enacted licensing requirements to help prevent prohibited individuals from purchasing firearms. Different types of firearm licensing laws exist in states. Permits-to-purchase (PTP) licensing systems require prospective firearm purchasers to have direct contact with law enforcement or judicial authorities that review the purchase application and verify the passage of a background check. While similar to PTP laws, license to own firearm laws differ in that the license must remain valid for as long as the person owns the firearm. Firearm safety certificates require completion of a required safety training course as a part of the firearm licensing process in addition to the passage of a background check. Firearm registration laws require individuals to record their ownership of a firearm with a designated law enforcement agency.

PTP laws, which have been enacted in 10 states and the District of Columbia, are the most common type of firearm licensing laws. In these jurisdictions, both licensed and unlicensed dealers can only sell firearms to individuals with a current PTP license, closing the loophole that exists under federal law. While the licensing requirements vary by state, they generally require an individual to fill out a license or permit application form, submit the form in-person to the licensing authority, and pay the required fees. A background check through the NICS is usually required. Some states also require fingerprints to be taken as a part of the application process. In some jurisdictions (Massachusetts, New York and New Jersey), law enforcement agencies have discretion in denying a permit. If approved, the permit or license is issued. State licensing laws usually apply to specific types of firearms (i.e., handguns or long guns and rifles).

States with PTP laws tend to have lower firearm-related death rates than states without these laws after controlling for demographic, economic and other differences across states. Evidence suggests that state laws leading to tighter regulation of sale and possession of firearms, including PTP laws, reduce the availability of in-state guns involved in crimes and traced by law enforcement. Furthermore, criminals who used firearms in places with PTP laws typically acquired them from states with weaker laws. PTP laws also are associated with reductions in firearm homicide and suicide rates. Connecticut’s PTP law was associated with a 40 percent reduction in firearm homicide rates during the first 10 years the law was in place while there was no evidence for a reduction in non-firearm homicides. Missouri’s firearm-related homicide rate 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. A study conducted in large urban counties found that PTP laws were associated with a 14 percent reduction in firearm homicides. 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.

**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. 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. 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. 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.

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. 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. Coordination challenges involved getting hospitals and departments of mental health to collaborate with law enforcement, who make the majority of records available to NICS. 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. As of July 2015, there were 3.8 million state-submitted mental health records in the NICS. 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. 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. 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. 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
that relevant information can be reported for this important public safety purpose. The rule specifically prohibits the disclosure of diagnostic or clinical information from medical records or other sources, and any mental health information beyond the indication that the individual is subject to the federal mental health prohibitor, and does not apply to most treating providers.30

Education Records. The Family Educational Rights and Privacy Act (FERPA) is a Federal law that protects the privacy of student education records. Due to the nature of mental health records reported to the NICS, schools are not likely to be among the organizations reporting. However, FERPA does have an exception that allows educational agencies and institutions to disclose personally identifiable information from education records to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health and safety of the student or other individuals.31 The information may be disclosed to any person whose knowledge of the information is necessary to protect the health or safety of the student or other individuals.

CONCLUSION

The AMA House of Delegates adopted policy at A-18 to require the licensing of all firearm owners. PTPs are a type of license, thus a separate policy requiring a permit prior to the sale of rapidly-firing semi-automatic firearms is not necessary. This requirement is encompassed in the existing licensing policy. However, amending the policy to clarify that permits are a type of license would be helpful to avoid future confusion.

In terms of mental health reporting, several national reports have identified the technological, coordination, and legal (i.e., privacy) challenges that limit states’ ability to report mental health records to the NICS. In recent years, progress has been made to increase the reporting of these records through the enactment of state reporting requirements, federal grants to states to address collaboration through state level task forces focused on NICS improvement, training to help identify the records that should be reported, automated transfer of mental health data to the NICS, and clarification of federal privacy laws. In addition, legislation was enacted by Congress as part of the FY 2018 Omnibus Appropriations bill—the Fix NICS Act of 2017—that, among other provisions, requires states to develop a plan to ensure maximum coordination and automation of the reporting the NICS.32 The law also reauthorizes NARIP through FY 2022.33 While existing AMA policy supports a waiting period and background checks for all firearm purchases, AMA policy does not currently address deficiencies in the current NICS system.

In addition to the NICS system, it is important to have policies in place that remove current access to firearms rather than just preventing the purchase of new firearms by individuals who are at high or imminent risk for harming themselves or others. The Council on Science and Public Health report and recommendations on “The Physician’s Role in Firearm Safety,” at A-18 led to the adoption of policy addressing the removal of firearms from high risk individuals, which includes support for gun violence restraining orders. Since overlapping policy on gun violence restraining was adopted and appended to Policy H-145.996, “Firearm Availability.” We recommend 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 resolus 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 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 in court for their rights to be restored. (Modify Current HOD Policy)


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


2 27 C.F.R. §478.11

3 27 C.F.R. §478.11


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.

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.
29 81 FR 382
31 34 CFR 99.36
32 Public Law No: 115-141.
33 Public Law No: 115-141.
Res. 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)

Whereas, AMA Policy H-180.956, “Physician Privileges Application – Timely Review by Managed Care,” states Medicare, Medicaid, and managed care organizations should retroactively compensate physicians for services rendered from the date of their credentialing; and

Whereas, HB 139 was successfully passed by the 2018 Virginia General Assembly and signed into law by Governor Northam. This allows physicians who are waiting to be credentialed by a health plan to see patients and retroactively receive payments if they are ultimately credentialed; and

Whereas, Physicians awaiting credentialing could be reimbursed $1000 per day during the credentialing process (Virginia Medical News – Spring/Summer 2018); therefore be it

RESOLVED, That our American Medical Association develop model state legislation for physicians being credentialed by a health plan to treat patients and retroactively receive 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.

Whereas, The opioid-overdose epidemic has had a devastating impact throughout the United States and currently claims about 115 lives per day (1); and

Whereas, The Centers for Disease Control and Prevention in August 2018 reported a record 72,000 overdose deaths in 2017 (2); and

Whereas, Medications for opioid use disorder can facilitate recovery and prevent deaths (3); and

Whereas, Great Britain, Canada and Australia have successfully made methadone available by prescription, enhancing access to this valuable therapy (1); and

Whereas, Limited experience in the United States over a 10-year period has demonstrated the success of such a primary care approach for treatment of opioid use disorder (1); and

Whereas, In 2001, there was a six-month randomized controlled trial that supported the success of such a primary care based approach (4, 5); and

Whereas, Enhancing the opportunity for primary care practices to prescribe methadone might increase the availability of such treatment in non-urban populations who lack access to methadone clinics; and

Whereas, AMA Policy H-95.957 supports the concept 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….”; therefore be it

RESOLVED, That our American Medical Association identify and work to remove those administrative and/or legal barriers that hamper the ability of primary care providers to prescribe methadone, through all appropriate legislative and/or regulatory means possible (Directive to Take Action); and be it further

RESOLVED, That our AMA, working with other federation stakeholders, identify the appropriate educational tools that would support primary care physicians to provide ongoing methadone treatment for appropriate patients. (Directive to Take Action)

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

Received: 09/21/18
References:
(2) https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates

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.
Modified: CSAPH Rep. 1, A-10
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-compliance2,3; 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 HIPAA3,4; 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.
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)
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-loomiing-physician-shor/.
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.
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”
“Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children Memorandum,”
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.

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 U.S. 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)
Whereas, Reporting data under the Merit-based Incentive Payment System (MIPS) increases the administrative burden on physicians and takes time away from patient care; and

Whereas, The maximum potential payment penalty under MIPS will incrementally increase to 9%; and

Whereas, Many physician practices that serve Medicare beneficiaries cannot sustain additional reductions in their Medicare payments; and

Whereas, Small and medium-sized physician practices are likely to be disproportionately impacted by penalties under MIPS; and

Whereas, Participation in pay-for-performance programs should not be compulsory; therefore be it

RESOLVED, That our American Medical Association advocate to repeal all potential penalties 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
Whereas, Affirmative action is a race-conscious recruitment policy designed to equalize access to jobs and professions such as medicine and is based on the premise that relief from illegal racial discrimination is not enough to remove the burden of second-class citizenship from underrepresented minority groups;¹ and

Whereas, Affirmative action has been identified as a potent method for ameliorating racial disparities and increasing diversity in public universities;²,³ and

Whereas, University enrollment is directly correlated with attaining higher social status;⁴ and

Whereas, Diversity in the student body fosters a greater understanding of patient populations and preparation for medical care to an increasingly multicultural society;⁵,⁶ and

Whereas, Underrepresented minority physicians are more likely to practice in underserved areas and tend to serve populations with higher percentages of medically indigent patients.;⁷-⁹ and

Whereas, Affirmative action has shown to increase medical practice in underserved areas with minority populations and providing better healthcare for various communities;¹⁰ and

Whereas, Several states that have instituted bans on affirmative action have experienced subsequent decreases in college enrollment by minority students, completion of STEM degrees by minority students, and representation of minority students among matriculating medical school students;²,³,¹¹,¹² and

Whereas, In 1978, 2003, and 2016 the supreme court upheld affirmative action in the cases of Regents of the University of California v. Bakke, Grutter v. Bollinger, and Fisher v. The University of Texas at Austin, respectively, allowing race to be one of several factors in college admission policy;¹³-¹⁵ and

Whereas, Although AMA policy establishes a significant precedent to support undergraduate education as a means to produce medical school matriculants (H-60.917, H-350.979, H-200.985), existing policy falls short of addressing the necessity of affirmative action as mechanism for equality at the undergraduate level, which is necessary to bolster the pool of minority students able to apply to a medical program; and

Whereas, The Department of Justice has announced the intent to investigate and potentially sue institutions utilizing affirmative action, threatening the principles of racial equality in education that our AMA supports;¹⁶ therefore be it
RESOLVED, That our American Medical Association oppose legislation that would undermine institutions’ ability to properly employ affirmative action to promote a diverse student population. (New HOD Policy)

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

Received: 09/28/18

References:


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/CLRDP 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
Whereas, Our AMA recognizes that social determinants of health, including circumstances of early life, social gradient, unemployment, and social exclusion, should be taught in medical school (H-295.874) and built into payment models (H-160.896); and

Whereas, Residents of rural areas in the United States tend to be older and sicker than their urban counterparts with higher rates of poverty, less access to healthcare, and higher likelihood of dying from 5 leading causes of death when compared to their urban counterparts; and

Whereas, 23 million Americans live in areas that do not have broadband internet access; and

Whereas, Broadband internet provides access to resources not only for health care but also for economic growth and job opportunities, educational opportunities, and government services; and

Whereas, Our AMA has a broad swath of policies which encourage the use of, and pay for, telemedicine, which requires broadband internet; and

Whereas, The Federal Communications Commission Connect2Health Task Force is currently exploring the intersections of health and technology in rural areas; therefore be it

RESOLVED, That our American Medical Association advocate for the expansion of broadband 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
Whereas, Although the AMA has existing policy on the education and prevention of sexual assault on college campuses, many adolescents have become victims of sexual assault and AMA policy does not explicitly address this topic for this age group; and

Whereas, More than forty-two percent (42.2%) of forced sexual violence victims are assaulted before they are 18 years old\(^1\); and

Whereas, More than eleven percent (11.3%) of female high school students and 3.5% of male high school students responding to the 2017 National Youth Risk Behavior Survey reported victimization by forced sex\(^2\); and

Whereas, The 2017 National Youth Risk Behavior Survey also notes the incidence of forced sex has failed to improve over the last decade among high school students\(^2\); and

Whereas, A significantly higher percentage of female students (10.7%) reported this sexual dating violence in the past year compared to male students (2.8%)\(^2\); and

Whereas, Both forced sex and sexual dating violence disproportionately affects sexual minorities in high school with 21.9% of lesbian, gay, or bisexual youth reporting forced sex (compared to 5.4% of heterosexual youth)\(^2\); and

Whereas, At least two states (California and Missouri) require education of high school students regarding consent as part of a mandate to teach about healthy relationships, and several others have recently considered such legislation as the majority of U.S. teens may graduate high school without any formal instruction on consent\(^4-6\); therefore be it

RESOLVED, That our American Medical Association support state legislation mandating that public middle and high school health education programs include age appropriate information on sexual assault education and prevention, including but not limited to topics of consent and sexual bullying. (Directive to Take Action)

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

Received: 09/28/18
References:

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, 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 diseases;
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
Whereas, Ethical guidelines for transplantation are set forth by our AMA, the World Medical
Association and the World Health Organization; the medical profession has the responsibility to
protect the rights and interests of patients who need and seek transplant surgery, as well as to
protect the rights and interests of organ donors whose organs may have been procured in
unethical manner; and

Whereas, China is second only to the United States as the country that performs the largest
number of transplants and thus has a particular responsibility to act ethically and transparently
regarding organ transplants; and

Whereas, Systematic, state-sanctioned organ harvesting from executed prisoners and prisoners
of conscience in China has occurred with the knowledge of the Chinese government; and there
are also reports about forced organ harvesting from Uighurs, House Christians, Tibetans and
Falun Gong practitioners; and

Whereas, The U.S. Congress passed House Resolution 343 in 2016, calling for an end to
forced organ harvesting from Falun Gong prisoners of conscience in China; and the European
Parliament also passed Written Declaration 48 in 2016, calling for investigations and an end to
forced organ harvesting from Falun Gong prisoners of conscience in China; and

Whereas, Doctors Against Forced Organ Harvesting (DAFOH), a medical NGO that was
nominated twice for a Nobel Peace Prize, collected over 3 million signatures for a petition to the
U.N. High Commissioner for Human Rights, calling for an end to forced organ harvesting in
China; and

Whereas, Chinese transplant numbers have increased dramatically and transplant tourism has
become a lucrative source of income in China, leading to a rapid expansion of the transplant
infrastructure in China; and China has declared the Hainan Islands to be a special economic
zone for medical tourism; therefore be it

RESOLVED, That our American Medical Association reaffirm Ethical Opinion E-6.1.1,
“Transplantation of Organs from Living Donors,“, and believes that transplant surgeons,
especially those who come to the United States for training in transplant surgery, must agree to
these guidelines, and that American medical and hospital institutions not be complicit in any
ethical violations or conflicts of interest (New HOD Policy); and be it further
RESOLVED, That our AMA representatives to the World Medical Association request an independent, interdisciplinary (not restricted to transplant surgeons), transparent investigation into the Chinese practices of organ transplantation including (but not limited to): the source of the organs as well as the guidelines followed; and to report back on these issues as well as the status of Prisoners of Conscience as sources of transplantable organs (Directive to Take Action); and be it further

RESOLVED, That our AMA call upon the U.S. Government to protect the large number of transplant tourists by implementing legislation to regulate the evolving, ethical challenges by initiating a Reciprocal Transplant Transparency Act which would blacklist countries that do not meet the same transparency and ethical standards practiced in the U.S. (such as the public listing of annual transplant numbers by every transplant center to permit scrutiny). (Directive to 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 individuals life or health, including psychosocial factors that would disqualify the individual from donating; address the individuals specific needs; and explore the individuals 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
Whereas, Sudden cardiac arrest (SCA) affects over 40,000 people in the public environment annually in the United States and early and prompt bystander automated external defibrillator (AED) use has been shown to be key for survival from SCA¹; and

Whereas, Current research have shown that AEDs are used in less than 5% of public SCA events²; and

Whereas, Despite efforts to establish AED availability in schools, workplaces and public spaces (as supported by AMA Policy H-130.938), studies have shown that the majority of the public either cannot identify an AED or are not aware of where AEDs are located²; and

Whereas, Due to the combination of inadequate public education about AED use, presence of labeling on AEDs that state "Trained Responders Only", and variations in state legislation with respect to legal protection for "Good Samaritans" who use AEDs, most laypersons are not aware that AEDs can be used by non-medical professionals³; therefore be it

RESOLVED, That our American Medical Association update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications (New HOD Policy); and be it further

RESOLVED That our AMA urge AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators (Directive to Take Action); and be it further

RESOLVED That our AMA support consistent and uniform legislation across states for the legal protection of untrained personnel who use AEDs in the course of attempting to aid a sudden cardiac arrest victim. (Directive to Take Action)

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

Received: 09/26/18
REFERENCES


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)
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;¹²,¹³ 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:

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.


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.


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, interprofessional 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
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; 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; and

Whereas, Research spending on firearm injuries conducted by the CDC fell by 96% from 1996 to 2012; 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; 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; 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; and

Whereas, CAP laws are currently active in twenty-seven states as well as Washington D.C.; 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; 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; 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); 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:

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
WHEREAS, Firearm deaths are a leading cause of preventable suicide, homicide, injury and
disability in the USA; and

WHEREAS, In the USA in 2016, there were on average 97 firearm deaths per day, 35,476 total,
two thirds of which were suicides affecting mostly young black men and older white men; and

WHEREAS, In the ten years ending in 2016, deaths from firearms totaled more than the
cumulative deaths of American soldiers in WW 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;” 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 … ;” 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; 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%; 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; 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
suggesting the time for action by organized medicine has arrived; therefore be it
RESOLVED, That our American Medical Association support a public health approach to evidence-based firearm laws and regulations that do not conflict with the Second Amendment to the U.S. Constitution (New HOD Policy); and be it further

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.

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.
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

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4 https://en.wikipedia.org/wiki/Militia, accessed January 29, 2018
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
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
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/later 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/later 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.
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/later 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. Physicians 65 and older currently represent 26.6 percent of all physicians in the United States. 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. 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.

Evidence supports findings that physical health and some cognitive abilities decline with aging. Research shows that cognitive dysfunction is more prevalent among older adults, although aging does not necessarily result in cognitive impairment. 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. Other factors may influence clinical performance, i.e., practice setting, lack of board certification, high clinical volume, certain specialty practices, etc. Fatigue, stress, burnout, and health issues unrelated to aging are also risk factors that can affect clinical performance. Performance also may be broadly determined by characteristics ranging from intelligence to personality. 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
addition, the participants felt that a set of guiding principles should be developed to reflect the
values and beliefs underlying any guidelines that may be developed for screening and assessing
senior/late career physicians.

July 19, 2016 Work Group Conference Call

The purpose of this conference call was to convene a smaller group of participants to develop
guiding principles to support the subsequent development of guidelines to screen and assess
senior/later career physicians. During the call, the conversation focused upon the thresholds at
which screening/assessment should be required. Although physicians of all ages can be assessed
“for cause,” the group discussed whether age alone is a sufficient cause for some kind of
monitoring beyond what is typical for all physicians. Other factors discussed included the influence
of practice setting and medical specialty, as well as the metrics and standards for different settings
that would have to be developed to determine at “what age” and “how do you test,” etc. The need
for surveillance, associated risk factors, and the ability to take appropriate steps, if needed, were
also discussed. It was noted that there is a need to be able to fairly and equitably identify physicians
who may need help while assuring patient safety. It was also noted that very few hospitals have
specific age guidelines, and that there was evidence that the number of disciplinary actions increase
at ages 65 and 70. The cost of and who will pay for screening/assessments were also discussed.

The group felt that more information and data were needed before the guiding principles could be
finalized and agreed to reconvene after gathering more information and studying evidence-based
data from the United States and other countries related to age and risk factors.

December 15, 2017 Work Group Conference Call

The purpose of this conference call was to reconvene the same smaller group of participants to
review the literature and data that had been gathered, and to finalize guiding principles to support
the subsequent development of guidelines to screen and assess senior/late career physicians.
Background information to help guide the development of the guiding principles included:

1. Results from a survey of members of the Federation of State Medical Boards (FSMB),
Council of Medical Specialty Societies (CMSS), and International Association of Medical
Regulatory Authorities (IAMRA) regarding the screening and assessment of senior
physicians.

2. A literature review of available data related to senior physician screening and assessment,
focusing on international work in this area.

3. Data from large health systems regarding their screening and assessment policies and
procedures.

Survey Results Related to Screening and Assessing Senior Physicians

To support the development of guiding principles, data were gathered through surveys of
professional associations (CMSS), state medical boards (FSMB), and international regulatory
authorities (IAMRA). The goal was to learn if these organizations had processes in place to screen
and assess senior physicians for clinical or cognitive competence, and if not, whether they had
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. 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. 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.

Studies related to professionalism, self-reporting, and peer review indicate that these methods are not always reliable. 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. 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.

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. 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. Individual and institutional considerations require a dialogue among the interested parties to optimize the benefits while minimizing the risks for both.

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.9 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.\textsuperscript{35} Anecdotal reports published in the \textit{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.\textsuperscript{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.\textsuperscript{35} In Russia and China, the mandated retirement age is 60 for men and 55 for women.\textsuperscript{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.\textsuperscript{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.\textsuperscript{26} Racine (Canada) suggested that physicians retire before health or competency issues arise.\textsuperscript{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.\textsuperscript{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.\textsuperscript{40}

\textbf{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,\textsuperscript{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,\textsuperscript{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.\textsuperscript{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.\textsuperscript{41}
The American College of Obstetricians and Gynecologists (ACOG) recommends that when evaluating an aging physician, focus should be placed on the physician’s quality of care provided to patients. ACOG’s recommendations regarding the later-career obstetrician–gynecologist also state that: 1) it is important to establish systems-based competency assessments to monitor and address physicians’ health and the effect age has on performance and outcomes; 2) workplace adaptations should be adopted to help obstetrician–gynecologists transition and age well in their practice and throughout their careers; and 3) to avoid the potential for legal challenges, hospitals should address the provisions of the Age Discrimination in Employment Act, making sure that assessments are equitably applied to all physicians, regardless of age.

At Kaiser Permanente, within its Permanente Medical Group, physicians are classified as “in partnership” or “incorporated.” In a region where a partnership exists, such as Southern California, the mandatory retirement age as a partner is at the end of the calendar year when one turns 65. Southern California Permanente Medical Group has approximately 3,000 partners, of which 300 retire each year at full retirement age. In the incorporated regions, there is no mandatory retirement for clinicians. In the partnership regions, retired physicians (partners emeritus) may apply for employment at age 66, but they are not guaranteed employment. If granted employment, these physicians see a dramatic decrease in remuneration, and they are usually not required to have a patient panel. Rehiring is at the discretion of the medical director and the budget. Therefore, a limited number of opportunities are available. Approximately 10 percent of these physicians apply for rehiring, and approximately 15 to 20 percent of those are rehired. They are usually limited to no more than 20 hours per week performing either clinical or administrative work. As a result, very few Permanente physicians work until age 70 or older.

The University of California, San Diego, Physician Assessment and Clinical Education (PACE) Program is the largest assessment and remediation program for health care professionals in the country. Recently, PACE conducted a pilot screening project to assess physicians. Thirty volunteer physicians, aged 50 to 83, were recruited to participate in the screening regimen. Preliminary data analysis showed that a number of senior physicians performed less than optimally (seven of 30 participants). However, when age-based capacity was reviewed (i.e., did those individuals between 50 to 59 or those between 60 to 69 years old perform better than those age 70 and older), the results were not statistically significant. The pilot study did have sufficient power to reach significance. However, the trend of the data was that older physicians did perform less optimally. It was also noted that 75 percent of the physicians who didn’t perform well on the MicroCog (a computerized assessment that detects early signs of cognitive impairment) were still working in a clinical capacity. The study did not include enough participants to provide a breakdown on specialties.

PROPOSED GUIDING PRINCIPLES

The Council on Medical Education proposes a set of guiding principles as a basis for developing guidelines for the screening and assessment of senior/later 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.

The Council developed the following eight guiding principles with extensive feedback from members of the AMA Work Group on Assessment of Senior/Late Career Physicians as well as feedback from other content experts who research physician competence and administer screening 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.
g) Supportive: Education and/or remediation practices that result from screening and/or assessment procedures should be supportive of physician wellness, ongoing, and proactive.

h) 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. (New HOD Policy)

2. That our AMA encourage the Federation of State Medical Boards, Council of Medical Specialty Societies, and other interested organizations to develop educational materials on the effects of age on physician practice for senior/late career physicians. (Directive to Take Action)

3. That Policy D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career 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: CLRDP 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.
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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.
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. 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. 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.
In 2017, Congress eliminated the individual mandate penalty for not having health insurance (effective 2019); 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.

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.

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.”
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. 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, several of which (population health,
leadership principles for women in medicine) are directly related to this report.
Recently, the ACP released a position paper noting that, “The American College of Physicians recommends that social determinants of health and the underlying individual, community, and systemic issues related to health inequities be integrated into medical education at all levels.” The paper also reviews particular health challenges associated with rural locations.

**Efforts of the Accelerating Change in Medical Education Consortium**

Many Accelerating Change in Medical Education Consortium members have been working to address population, public, and rural health education at the UME level.

- The partnership between A.T. Still University’s School of Osteopathic Medicine in Arizona and the National Association of Community Health Centers embeds second-, third-, and fourth-year medical students in rural health centers. Additionally, second-year students participate in a year-long course in epidemiology, biostatistics, and preventive medicine, during which they work with community stakeholders and health centers to identify and address local issues of community concern.
- The Brody School of Medicine at East Carolina University integrates a population health component into its comprehensive longitudinal core curriculum.
- Case Western Reserve University School of Medicine incorporates a patient navigator model into its curriculum, and medical student navigators learn to use and create registries for population health management in specific population groups.
- The curriculum at Dell Medical School at the University of Texas at Austin is built around instruction in leadership, which is incorporated into all four years of education. During the third year, students can choose to focus on specific areas of study, including population health.
- Upon joining the consortium, Florida International University Herbert Wertheim College of Medicine enhanced its “Green Family Foundation Neighborhood Health Education Learning Program” (NeighborhoodHELP™), which provides a longitudinal, interprofessional community-based experience for medical students and partnerships with local hospitals.
- The blended learning curriculum at the Mayo Clinic School of Medicine focuses on six content domains, one of which is population-centered care. Students can also pursue an additional 12 credits to receive a master’s degree in health care delivery science, which includes instruction in population and preventive health. Further, Mayo has created milestones for students related to population health in alignment with ACGME competencies.
- The New York University School of Medicine’s Health Care by the Numbers curriculum uses very large de-identified datasets to train students to improve the health of populations.
- Ohio University Heritage College of Osteopathic Medicine integrates population health into its continuous, longitudinal curriculum.
- The University of Connecticut School of Medicine’s MDelta curriculum has been specifically designed so that all students can achieve a certificate in public health, with a specific focus on disparities and the social determinants of health. Additionally, the school has incorporated the Regenstrief EHR Clinical Learning Platform into the MDelta curriculum. This platform includes large numbers of de-identified patient records, allowing students to research population health issues.
- The University of Nebraska Medical Center College of Medicine, through its focus on interprofessional education, has established official partnerships with its colleges of nursing, public health, pharmacy, dentistry, and allied health professions.
- The University of North Dakota School of Medicine and Health Sciences incorporates training in the use of telemedicine to connect remote patients and providers at multiple locations.
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, 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. 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.

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. 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. 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.

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. 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. (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.)

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.”

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, three are combined family medicine/preventive medicine programs, and six are
combined internal medicine/preventive medicine programs. Furthermore, of the 11,300 ACGME-accredited programs in all specialties, 357 indicated that they offer a separate rural track.

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).

For medical school graduates, public/population health training opportunities exist beyond
combined residency training programs. The AAMC curates a list of public health pathways. 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.

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.
• The American Association of Public Health Physicians (AAPHP), founded to provide a voice to physician directors of state and local health departments at the national level, offers publicly available educational resources, ranging from ethics in public health, food safety, fracking, and gun violence/racism prevention.30

• In addition to a collection of reports, educational webinars, and policy statements on a broad range of public health topics, the American Public Health Association offers a substantial number of internships (not limited to physicians-in-training or physicians) in topics ranging from environmental health, government relations, injury and violence prevention, and public health policy, as well as a Public Health Fellowship in Government. This fellowship places future public health leaders into positions as staff members for elected officials in Congress.31

• The National Association of County and City Health Officials (NACCHO) offers a publicly available “toolbox” focusing on public health tools created by and for members of the public health community. Tools range from emergency preparedness and vector control to public engagement and injury and violence prevention. NACCHO also offers a library of best practices related to chronic disease management intended to help local health departments stay current in both knowledge and interventions.32 Furthermore, NACCHO University is an online learning hub where public health professionals can access training and develop competencies.33 Finally, NACCHO Consulting works with local public health departments on research and evaluation projects, performance improvement, workforce development, and public health topics.34

• The CDC has compiled a resource list “for health professional students, educators, and health professionals to learn more about issues affecting individuals at a population level, to become more familiar with other population health issues, to integrate public health into existing curricula, and for increased collaboration with public health.”35 This list comprises collaborative efforts, competencies, curricula, training opportunities, and peer-reviewed publications, among other resources.

• The Public Health Leadership Forum, funded by the Robert Wood Johnson Foundation, seeks to engage public health leaders and stakeholders in efforts that promote transformation in the field of public health.36 The Forum has worked on a number of impactful projects, including the development of a set of foundational public health services for public health departments and the visioning of the future of high-functioning public health departments.

• The Association of State and Territorial Health Officials (ASTHO) has developed a list of educational tools and resources that support cooperation between public health and primary care organizations.37 ASTHO also provides resources to state and territorial health officials regarding proven and cost-effective population health improvement approaches.38

• The National Network of Public Health Institutes serves as the national coordinating center for ten regional public health training centers and 40 additional local sites to “offer high-quality training, tools, and resources for thousands of professionals engaged in the critical work of advancing public health practice and improving population health,”39 and serves as facilitator of the Public Health Learning Network. These training centers and affiliate sites focus on building skills in change management, communication, diversity/inclusion, 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). 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.”

• 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.”

Additional AMA Resources

The AMA’s STEPS Forward™ library includes a module on Project ECHO™, which is specifically designed to help coordinate care across rural areas in need of certain specialty care. Additionally, the AMA published a STEPS Forward™ module on social determinants of health in September 2018.

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 textbook 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; looking at how public health leadership is currently defined; focusing on the specific skills and talents public health leaders require; and considering the risks and benefits of engaging non-clinician celebrity diplomacy.

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. Others note that evaluation of public health leadership interventions is often lacking.
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. 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.

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.

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. 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. That Policy D-295.311, “Developing Physician Led Public Health / Population Health Capacity in Rural Communities,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

2. That our American Medical Association (AMA) reaffirm the following policies:
   - D-295.327, “Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum”
   - D-305.964, “Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion”
   - D-305.974, “Funding for Preventive Medicine Residencies”
   - D-440.951, “One-Year Public Health Training Options for all Specialties”
   - H-440.954, “Revitalization of Local Public Health Units for the Nation”
   - H-440.888, “Public Health Leadership”
   - H-440.969, “Meeting Public Health Care Needs Through Health Professions Education” (Reaffirm HOD Policy)

3. That our AMA encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation Council for Graduate Medical Education (ACGME) to highlight public/population health leadership learning opportunities to all learners, but especially to women and those who are underrepresented in medicine. (Directive to Take Action)

4. That our AMA encourage public health leadership programs to evaluate the effectiveness 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.

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.


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.


(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.


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


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.

Oral communication, Allison Winkler, Senior Practice Development Specialist, American Medical Association.


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”
5. H-200.972, “Primary Care Physicians in the Inner City”
6. H-200.973, “Increasing the Availability of Primary Care 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”
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”
   5. H-200.973, “Increasing the Availability of Primary Care 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”
  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 underserved areas:

   (1) Encourage the creation and pilot-testing of school-based, church-based, and community-based urban/rural “family health 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 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.
(157) Urge urban hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to fill gaps in urban care and help meet the needs of underserved patient populations.

(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.

(17) Urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

(18) Continue to urge measures to enhance payment for primary care in the inner city. (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.

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<th>Proposed language for adoption</th>
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<tr>
<td>1. Our patients require a sufficient, well-trained supply of primary care physicians—family physicians, general internists, general pediatrics, and obstetricians/gynecologists—to meet the nation’s current and projected demand for health care services.</td>
<td>The AMA believes that there should be a sufficient supply of primary care physicians - family physicians, general internists, general pediatrics, and obstetricians/gynecologists. In order to achieve this objective: <strong>H-200.997</strong></td>
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<td>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).</td>
<td>(new)</td>
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<td>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:</td>
<td>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. <strong>D-200.979</strong></td>
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<td>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;</td>
<td>(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. <strong>H-200.997</strong></td>
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<td>b) Curriculum changes throughout the medical education continuum;</td>
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<td>c) Expanded financial aid and debt relief options;</td>
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<td>d) Financial and logistical support for primary care practice, including</td>
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<td>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.</td>
<td>primary care physicians to meet projected national needs. <strong>H-200.977</strong> 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. <strong>H-200.975</strong></td>
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<td>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 ... <strong>D-200.979</strong></td>
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<td>4. <strong>Admissions and recruitment:</strong> 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.</td>
<td>(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. <strong>H-200.973</strong></td>
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<td>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.</td>
<td>(3) Through early recruitment and outreach activities, attempts should be made to increase the pool of applicants likely to practice primary care. <strong>H-200.973</strong> (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. <strong>H-200.972</strong> (12) Encourage medical school outreach activities into secondary schools, colleges, and universities to stimulate students with these profiles to apply to medical school. <strong>H-200.972</strong></td>
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<td>6. <strong>Career counseling and exposure to primary care:</strong> 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.</td>
<td>(7) Medical schools should provide career counseling related to the choice of a primary care specialty. <strong>H-200.973</strong> 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</td>
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<td>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.</td>
<td>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. <strong>H-200.966</strong></td>
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<td>8. <strong>Curriculum</strong>: 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.</td>
<td>(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. <strong>H-200.997</strong></td>
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<td>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.</td>
<td>(4) Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. <strong>H-200.973</strong></td>
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<td>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.</td>
<td>(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. <strong>H-200.973</strong></td>
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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
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<td>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.</td>
<td>experiences in community-based primary care settings. D-200.979</td>
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<td>(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</td>
<td>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</td>
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<td>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</td>
<td>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</td>
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<td>2. Our AMA will encourage the Centers for Medicare &amp; 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</td>
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<td>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.</td>
<td>H-200.982</td>
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<td>(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.</td>
<td>H-200.972</td>
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<td>(4) Encourage medical schools and teaching hospitals to integrate third- and fourth-year undergraduate medical education and residency training into these teams.</td>
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<td>(8) The curriculum in primary care residency programs and the sites used for training should be consistent with the objective of training generalist physicians.</td>
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<td>(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.</td>
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<td>(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.</td>
<td>H-200.973</td>
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<td>professional satisfaction and practice sustainability.</td>
<td>(9) There should be increased financial incentives for physicians practicing primary care. <strong>H-200.973</strong></td>
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<td>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.</td>
<td>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. <strong>H-200.982</strong></td>
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<td>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&amp;M services and</td>
<td>(18) Continue to urge measures to enhance payment for primary care in the inner city. <strong>H-200.972</strong></td>
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<td>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&amp;M services and</td>
<td>(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. <strong>H-200.972</strong></td>
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<td>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. <strong>D-200.979</strong></td>
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<td>The AMA will (1) work with federal and state governments to develop incentive programs, such as loan repayment, to encourage practice in underserved areas, <strong>H-200.978</strong></td>
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<td>(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. <strong>H-200.973</strong></td>
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<td>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&amp;M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.</td>
<td>Committee (RUC) related to reimbursement for E&amp;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&amp;M services, incorporating the RUC recommended increases adopted for the most current Medicare RBRVS. <strong>D-200.979</strong></td>
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<td>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.</td>
<td>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. <strong>D-200.979</strong></td>
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<td>19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.</td>
<td>(11) There should be educational support systems for primary care physicians, especially those practicing in underserved areas. <strong>H-200.973</strong></td>
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<td>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.</td>
<td>(17) Urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities. <strong>H-200.972</strong></td>
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<td>21. Our AMA will encourage the Centers for Medicare &amp; Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.</td>
<td>(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. <strong>H-200.972</strong></td>
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<td>22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.</td>
<td>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. <strong>H-300.957</strong></td>
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<td>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,</td>
<td>(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. <strong>H-200.972</strong></td>
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<td>part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.</td>
<td>(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. <strong>H-200.972</strong></td>
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<tr>
<td>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.</td>
<td>Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747. <strong>H-200.956</strong></td>
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<td><strong>Research:</strong> 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.</td>
<td>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. <strong>H-200.966</strong></td>
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<td>(7) The AMA will encourage research to identify all factors which deter students and physicians from choosing and remaining in primary care disciplines <strong>H-200.978</strong></td>
<td>(2) engage in research to identify all factors which deter students and physicians from choosing and remaining in primary care disciplines <strong>H-200.978</strong></td>
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<td>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. <strong>D-200.979</strong> and (3) use this information to support and implement AMA policy to enhance primary care as a career choice. <strong>H-200.978</strong></td>
<td>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. <strong>D-200.979</strong> and (3) use this information to support and implement AMA policy to enhance primary care as a career choice. <strong>H-200.978</strong></td>
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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.


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.

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.

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.

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.

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.


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.
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.


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.


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
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:

2. H-310.907, “AMA Duty Hours Policy”
5. H-310.929, “Principles for Graduate Medical Education”
8. H-310.979, “Resident Physician Working Hours and Supervision”
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-310.979, “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:

   2) H-310.922, “Determining Residents’ Salaries”
   3) H-310.932, “Annual Contracts for Continuing Residents”
   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”_

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<td><strong>Policy Title:</strong> AMA duty hours policy</td>
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<tr>
<td><strong>Resident/Fellow Clinical and Educational Work Hours</strong></td>
<td><strong>Our AMA adopts the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training:</strong></td>
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<td><strong>Our AMA adopts the following Principles of Resident/Fellow Duty Hours:</strong></td>
<td><strong>1. Our AMA reaffirms support of the 2003 Accreditation Council for Graduate Medical Education (ACGME) duty hour standards.</strong></td>
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<td><strong>1. Our AMA reaffirms support of the 2003 Accreditation Council for Graduate Medical Education (ACGME) duty hour standards (previously referred to as “duty hours”).</strong></td>
<td><strong>(Note: The 2003 standards have been superseded by the 2017 standards.)</strong></td>
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<td><strong>2. Our AMA will continue to monitor the enforcement and impact of duty clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.</strong></td>
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<tr>
<td><strong>3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty 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.</strong></td>
<td><strong>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.</strong></td>
</tr>
<tr>
<td><strong>4. Our AMA endorses the study of innovative models of duty clinical and educational work hour requirements and, pending the outcomes of</strong></td>
<td><strong>4. Our AMA endorses the study of innovative models of duty hour requirements and, pending the outcomes of ongoing and future research,</strong></td>
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<tr>
<td><strong>ongoing and future research, should consider the evolution of specialty- and rotation-specific duty requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>5. Our AMA encourages the ACGME to:</strong></td>
<td><strong>(unchanged)</strong></td>
</tr>
<tr>
<td>a) Decrease the barriers to reporting of both duty clinical and educational work hour violations and resident intimidation.</td>
<td>a) Decrease the barriers to reporting of both duty hour violations and resident intimidation.</td>
</tr>
<tr>
<td>b) Ensure that readily accessible, timely and accurate information about duty clinical and educational work hours is not constrained by the cycle of ACGME survey visits.</td>
<td>b) Ensure that readily accessible, timely and accurate information about duty hours is not constrained by the cycle of ACGME survey visits.</td>
</tr>
<tr>
<td>c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of resident duty clinical and educational work hour rules.</td>
<td>c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of resident duty hour rules.</td>
</tr>
<tr>
<td>d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of duty clinical and educational work hours.</td>
<td>d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of duty hours.</td>
</tr>
<tr>
<td><strong>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:</strong></td>
<td><strong>(unchanged)</strong></td>
</tr>
<tr>
<td>a) Offer incentives to programs/institutions to ensure compliance with duty clinical and educational work hour standards.</td>
<td>a) Offer incentives to programs/institutions to ensure compliance with duty hour standards.</td>
</tr>
<tr>
<td>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.</td>
<td><strong>(unchanged)</strong></td>
</tr>
<tr>
<td>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.</td>
<td><strong>(unchanged)</strong></td>
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<tr>
<td>d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.</td>
<td><strong>(unchanged)</strong></td>
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<tr>
<td><strong>7. Our AMA supports the following statements related to duty clinical and educational work hours:</strong></td>
<td><strong>7. Our AMA supports the following statements related to duty hours:</strong></td>
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| a) **Resident physician total duty clinical and educational work hours must not exceed 80** | a) Resident physician total duty hours must not exceed 80 hours per week, averaged over a four-
### Proposed language for adoption

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<td>hours per week, averaged over a four-week period (Note: <strong>Total duty clinical and educational work hours</strong> 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).</td>
<td>week period (Note: <strong>Total duty hours</strong> 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).</td>
</tr>
<tr>
<td>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.</td>
<td>(unchanged)</td>
</tr>
<tr>
<td>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.</td>
<td>(unchanged)</td>
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<tr>
<td>d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.</td>
<td>(unchanged)</td>
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<tr>
<td>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.”</td>
<td>(unchanged)</td>
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<tr>
<td>f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, duty 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, to the 16-hour shift limit for first-year residents, or allowing a limited increase to the total number of duty clinical and educational work hours when need is demonstrated.</td>
<td>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.</td>
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<td>g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.</td>
<td>(unchanged)</td>
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<tr>
<td>h) Duty 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 duty clinical and educational work hour limits for all resident physicians.</td>
<td>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.</td>
</tr>
<tr>
<td>i) Scheduled time providing patient care services of limited or no educational value should be minimized.</td>
<td>(unchanged)</td>
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<tr>
<td>j) Accurate, honest, and complete reporting of resident duty clinical and educational work hours is an essential element of medical professionalism and ethics.</td>
<td>j) Accurate, honest, and complete reporting of resident duty hours is an essential element of medical professionalism and ethics.</td>
</tr>
<tr>
<td>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 &amp; 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 clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the duty work hours of practicing physicians.</td>
<td>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 &amp; 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.</td>
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<tr>
<td>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.</td>
<td>(unchanged)</td>
</tr>
<tr>
<td>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.</td>
<td>(unchanged)</td>
</tr>
<tr>
<td>n) The costs of duty clinical and educational work hour limits should be borne by all health care payers.</td>
<td>n) The costs of duty hour limits should be borne by all health care payers.</td>
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<td>care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.</td>
<td>(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</td>
</tr>
<tr>
<td>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.</td>
<td>(unchanged)</td>
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<tr>
<td>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.</td>
<td>(unchanged)</td>
</tr>
<tr>
<td>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.</td>
<td>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</td>
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CME Rep. 5, A-14
### Proposed language for adoption

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<tr>
<td>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.</td>
<td>(unchanged)</td>
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<tr>
<td>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.</td>
<td>(unchanged)</td>
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<tr>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>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</td>
<td>(unchanged)</td>
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<td>within one month of document submission is strongly recommended.</td>
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<td>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.</td>
<td>(unchanged)</td>
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<tr>
<td>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:</td>
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<tr>
<td><strong>RESIDENTS AND FELLOW PHYSICIANS’ BILL OF RIGHTS</strong></td>
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<td>Residents and fellows have a right to:</td>
<td>(unchanged)</td>
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<tr>
<td>A. An education that fosters professional development, takes priority over service, and leads to independent practice.</td>
<td>(unchanged)</td>
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<tr>
<td>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.</td>
<td>(unchanged)</td>
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<tr>
<td>B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.</td>
<td>(unchanged)</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
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<td>It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.</td>
<td>(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.”</td>
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<td>C. Regular and timely feedback and evaluation based on valid assessments of resident performance.</td>
<td>(unchanged)</td>
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<td>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.</td>
<td>(unchanged)</td>
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<td>D. A safe and supportive workplace with appropriate facilities.</td>
<td>(unchanged)</td>
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<td>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.</td>
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<td>E. Adequate compensation and benefits that provide for resident well-being and health.</td>
<td>(unchanged)</td>
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<td>(1) With regard to contracts, residents and fellows should receive: a. Information about the</td>
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<td>interviewing residency or fellowship program including a copy of the currently used contract</td>
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<td>clearly outlining the conditions for (re)appointment, details of remuneration,</td>
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<td>specific responsibilities including call obligations, and a detailed protocol for handling</td>
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<td>any grievance; and b. At least four months advance notice of contract non-renewal and the</td>
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<td>reason for non-renewal.</td>
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<td>(2) With regard to compensation, residents and fellows should receive: a. Compensation for</td>
<td>(2) With regard to compensation, residents and fellows should receive: a. Compensation for</td>
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<td>time at orientation; and b. Salaries commensurate with their level of training and experience,</td>
<td>time at orientation; and b. Salaries commensurate with their level of training and experience,</td>
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<td>Compensation should and that reflect cost of living differences based on geographical</td>
<td>and that reflect cost of living differences based on geographical differences.</td>
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<td>differences, local economic factors, such as housing, transportation, and energy costs (which</td>
<td>Our AMA encourages teaching institutions to base residents’ salaries on the resident’s level of</td>
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<td>affect the purchasing power of wages), and include appropriate adjustments for changes in the</td>
<td>training as well as local economic factors, such as housing, transportation, and energy costs,</td>
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<td>amount of paid vacation leave, sick leave, <strong>maternity and paternity</strong>, 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; and 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.</td>
<td>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. H-310.947</td>
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F. Duty Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.  

With regard to **duty clinical and educational work 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. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.  

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.  

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. (unchanged)  

H. Access to and protection by institutional and accreditation authorities when reporting violations. (unchanged)
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<td>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.</td>
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<tr>
<td>Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in the revised &quot;Institutional Requirements&quot; of the Essentials of Accredited Residencies of Graduate Medical Education, if they are not already present.</td>
<td>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.</td>
</tr>
<tr>
<td>(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.</td>
<td>(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. (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. (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.</td>
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<tr>
<td>(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.</td>
<td>(unchanged)</td>
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<td>(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.</td>
<td>(unchanged)</td>
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<td>(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.</td>
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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 Essentials for Accredited Residencies in Graduate Medical Education 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
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<td>residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.</td>
<td>similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.</td>
</tr>
<tr>
<td>(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.</td>
<td>(unchanged)</td>
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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)application, 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.

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(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”*

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<td>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.</td>
<td>Still relevant, but rescind and append to H-310.907 (9), “AMA duty hours policy.”</td>
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<td>Res. 314, A-03 Reaffirmation A-12</td>
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*H-310.922, “Determining Residents’ Salaries”*

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<td>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.</td>
<td>Still relevant, but rescind and incorporate into H-310.912 (E.2), “Residents and Fellows’ Bill of Rights.”</td>
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*H-310.932, “Annual Contracts for Continuing Residents”*

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| 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.” |

*H-310.947, “Revision of the ‘General Requirements’ of the Essentials of Accredited Residency Programs”*

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<td>The AMA supports the following principles of the ACGME Institutional Requirements: Candidates for residencies must be fully informed of benefits including financial support,</td>
<td>Still relevant, but rescind and incorporate into H-310.912 (E.3), “Residents and Fellows’ Bill of Rights.”</td>
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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.

H-310.979, “Resident Physician Working Hours and Supervision”

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<td>(1) Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress:</td>
<td>Still relevant, but rescind and incorporate relevant aspects into other policies, as noted below.</td>
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<td>(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.</td>
<td>Incorporate into H-310.929 (1), “Principles for Graduate Medical Education.”</td>
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<td>(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.</td>
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<td>(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.</td>
<td>Incorporate relevant aspects into H-310.929 (12), “Principles for Graduate Medical Education.”</td>
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<td>(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.</td>
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<td>(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.</td>
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<td>(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.</td>
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| (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.” | Rescind; already reflected in H-295.858, “Access to Confidential Health Services for Medical Students and Physicians,” as follows: “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
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<td>(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.</td>
<td>Rescind; already reflected in H-310.912 (A), “Residents and Fellows’ Bill of Rights,” as follows: &quot;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.” Also reflected in H-310.907 (7), “AMA duty hours policy,” as follows: &quot;i) Scheduled time providing patient care services of limited or no educational value should be minimized.”</td>
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<td>(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.”</td>
<td>Incorporate into H-310.912 (B), “Residents and Fellows’ Bill of Rights.”</td>
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<td>(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.</td>
<td>Incorporate into H-310.907 (7.n), “AMA duty hours policy.”</td>
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<td>(2) These problems should be addressed within the present system of graduate medical education, without regulation by agencies of government.</td>
<td>Rescind; already reflected in H-310.907 (7), “AMA duty hours policy,” as follows: “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 &amp; 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.”</td>
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### H-310.988, “Adequate Resident Compensation”

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<td>The AMA believes that housestaff should receive adequate compensation by their training programs.</td>
<td>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.”</td>
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Reaffirmed: CME Rep. 1, A-15

### H-310.999, “Guidelines for Housestaff Contracts or Agreements”

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<td>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.</td>
<td>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 &amp; 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 <a href="https://www.ama-assn.org/life-career/understanding-employment-contracts">https://www.ama-assn.org/life-career/understanding-employment-contracts</a>).</td>
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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
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.

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.

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.”

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.

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
the housestaff, including the provision of adequate off-duty hours.

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.

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.

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
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.

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.

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.

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
procedures, 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.

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
Whereas, The American Medical Association has a very good, long-standing relationship with the Educational Commission for Foreign Medical Graduates (ECFMG); and
Whereas, The AMA has a dedicated section for international medical graduates, the AMA-IMG Section; and
Whereas, The AMA has the ability to appoint regularly one representative to the ECFMG Board of Trustees; and
Whereas, The ECFMG mission is to promote quality health care for the public by certifying international medical graduates for entry into U.S. graduate medical education, and by participating in the evaluation and certification of other physicians and health care professionals nationally and internationally; and
Whereas, IMGs are the main reason of existence of the ECFMG and represent 26% of the physician workforce in the U.S.; and
Whereas, IMGs are best suited to understand and decipher IMG issues; therefore be it
RESOLVED, That the American Medical Association ask the Educational Commission for Foreign Medical Graduates (ECFMG) to increase the number of international medical graduates (IMGs) proportionate to the percentage of IMGs serving in the U.S. on their councils, committees, and/or task forces. (Directive to Take Action)

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

Received: 09/28/18
Reference: https://www.ecfmg.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.

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.

Whereas, Since 2009 the U.S. Department of Education created several Income-Driven Repayment (IDR) plans that allow borrowers to select one of five plans for repaying their loans with base payment amounts based on the borrower's income and repayment periods extended from the standard ten years to up to twenty-five years with any remaining balance forgiven at the end of that period (these new loans went into effect for all new loans as of July 1, 2014)\(^1\); and

Whereas, The cost of these plans had not been adequately budgeted for by the Department of Education, leading to proposed budget cuts to programs including IDR plans and the Public Service Loan Forgiveness (PSLF) program\(^1-3\); and

Whereas, Our AMA has made a concerted effort to reduce the burden of student loan debt, but has not specifically address IDR plans and their relevance to current and future medical students; therefore be it

RESOLVED, That our American Medical Association advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student 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

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.


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
Whereas, The Veterans Health Administration (VHA) takes pride in providing the largest education and training enterprise for graduate medical education (GME), training over 40,000 resident physicians annually; and

Whereas, Resident physicians provide care directly to veterans and expand VHA’s clinical capacity, allowing VHA patients to be seen more quickly; and

Whereas, VHA provides care in a team-based, patient centered, interprofessional work environment with innovative technologies for care, which models the future of integrated health care delivery; and

Whereas, VHA is working to expand graduate medical education in primary care, mental health, and areas of physician shortages; and

Whereas, Increasing physician shortages nationwide are predicted in primary care and specialty care, including in the VA system; and 60% of current VHA physicians received training with VHA; and

Whereas, Our American Medical Association supports GME expansion; and

Whereas, The ongoing funding of the VA Missions Act expanding private health care options will cost billions and its funding may result in cuts to existing VHA programs; therefore be it

RESOLVED, That our American Medical Association continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration (VHA) funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose service obligations linked to VHA GME residency or fellowship positions, particularly for resident physicians rotating through the VA for only a portion of their GME training. (New HOD 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.

Whereas, On February 26, 2014, the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM) announced their agreement to a Memorandum of Understanding, outlining a single graduate medical education accreditation system in the United States;¹ and

Whereas, “By December 31, 2017, AOA programs that are three years or longer in length were required to apply to the ACGME in order to recruit residents in the 2018 AOA Match,” and the AOA training programs are no longer able to accept residents if they cannot complete their training by June 30, 2020;² and

Whereas, The listed benefits of the single accreditation system are to “ensure all residency and fellowship applicants are eligible to enter all accredited programs in the United States, and can transfer from one accredited program to another without repeating training, and without causing the Sponsoring Institutions to lose Medicare funding;”³ and

Whereas, In 2017, 709 residency programs across the United States participated in the National Match Service, the osteopathic version of NRMP, and as of January 2, 2018, 68% of those programs have applied for the single GME accreditation system;⁴ and

Whereas, The ACGME views the COMLEX and USMLE as equivalent licensing board exams and “does not specify which licensing board exam(s) (i.e., COMLEX-USA, USMLE) applicants must take to be eligible for appointment in ACGME-accredited residency programs;”⁶ and

Whereas, According to the 2016 NRMP Program Director Survey, for all specialties, only 77% of program directors use COMLEX Level 1 for pass only and with a target score in mind, but 99% of program directors use USMLE Step 1 for pass only and with a target score in mind;⁷ and

Whereas, According to the 2016 NRMP Program Director Survey, for all specialties, only 65% of Program Directors use COMLEX Level 2 PE, but 78% of Program Directors use USMLE Step 2 CS scores;⁷ and

Whereas, Original research yielded much lower COMLEX score acceptance with 51.6% of NRMP residency programs in Ohio, 53.3% of NRMP residency programs in Colorado, and 39.4% of NRMP residency programs in Utah reporting acceptance of COMLEX Step 1 scores;⁸-¹⁰ and
Whereas, As an examination constructed to assess the basic science knowledge of allopathic medical students, the NBME-CBSE is effective at predicting performance on COMLEX-USA Level 1 for osteopathic medical students, implying that the same basic science knowledge is expected for DO and MD students, and

Whereas, A recent study of 795 students from three osteopathic medical schools who took both USMLE Step 1 and COMLEX Level 1 found that scores were statistically significant across all three schools and that there was "a strong association between COMLEX Level 1 and USMLE Step 1 performance", and

Whereas, A formula exists to convert COMLEX Level 1 and USMLE Step 1 scores, however, research has shown that attempts to derive a USMLE score from a COMLEX score using the Slocum andLouder formula predicted lower scores by an average of 14.16 points (6.8%), and cautioned residency program directors from using such conversion methods, and

Whereas, Dr. Jon Gimpel, President of the NBOME, stated that "because of the different natures of the examinations, it is not possible—or even desirable—to make a direct numerical comparison between the scores of the COMLEX-USA examination series and those of the USMLE. When it comes to the examinations, the NBOME encourages residency program directors to consider the COMLEX-USA series as the valid and most appropriate assessment tool for osteopathic medical students. Our goal is to increase program directors' understanding of the COMLEX-USA examination series, including its content, development, validity, and scoring", and

Whereas, "The single GME accreditation system is not expected to reduce acceptance of the COMLEX-USA for residency admissions, but rather to continue to grow acceptance with the goal of one day achieving universal acceptance. However, it is likely – at least for a while – that some ACGME programs will continue to prefer to receive a USMLE score", and

Whereas, Equal acceptance of COMLEX and USMLE would still enable allopathic medical students to enter residency programs with osteopathic recognition since "Any graduate of a college of medicine accredited by the Commission on Osteopathic College Accreditation (COCA), medical school within the United States or Canada accredited by the Liaison Committee on Medical Education (LCME), or medical school outside of the United States or Canada that meets the established eligibility criteria will be eligible to enter an ACGME-accredited program, including any program with Osteopathic Recognition," therefore be it

RESOLVED, That our American Medical Association promote equal acceptance of the USMLE and COMLEX at all United States residency programs (New HOD Policy); and be it further

RESOLVED, That our AMA work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores (Directive to Take Action); and be it further

RESOLVED, That our AMA work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system. (Directive to Take Action)
Fiscal Note: Modest - between $1,000 - $5,000.

Received: 09/28/18

REFERENCES

Resolution: 955 (I-18)


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 remedying 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
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
RESOLVED, That our AMA work with interested stakeholders to study other ways to increase training in rural areas (Directive to Take Action); and be it further

RESOLVED, That our AMA formulate an actionable plan of advocacy based on the results of the above study with the goal of increasing residency training in rural areas. (Directive to Take Action)

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

Received: 09/28/18
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 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.


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)
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
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.)
The modern House of Delegates traces to the work of the Committee on Reorganization, which was established in 1900 and eventuated in the adoption of a new constitution and bylaws in 1901, redefining and modernizing the House of Delegates (Campion, 1984). Current membership became
the basis for apportioning delegates, as the Committee’s work established a House of Delegates based on proportional representation in which constituent associations were represented on the basis of one delegate for 500 members. The following year, in June 1902, the House adopted a resolution stating “That state associations or societies in counting members for a basis of delegate representation in this House shall count only members in good standing, who pay regular dues to the state association, either directly or indirectly through county societies.”

While the ratio of members per delegate has been adjusted over the last 100 plus years to accommodate growth in the physician population and membership, delegate apportionment has always been based upon the number of current members. The current ratio of one delegate per 1000 AMA members dates from 1946. The 1948 constitution prescribed that the “number of delegates from the constituent associations shall be proportional to the number of active members in the respective associations,” and that year saw the start of the annual apportionment process.

Two significant changes were effected in the early 1950s. At the December 1950 meeting, the members to be counted were explicitly defined to be AMA members: “The apportionment of delegates from each constituent association shall be one delegate for each thousand (1,000) or fraction thereof, dues paying active members of the American Medical Association (emphasis added).” Whereas before this time counts focused on members of the constituent associations, now the relevant population was specified to be AMA members. At the 1952 Annual Meeting, December 31 was set as the cutoff date for counting members to maximize the time allowed for societies to add members, with the effective date for apportionment January 1 (Proceedings of the House of Delegates, 1952).

Irrespective of how or when members join our AMA, under our current bylaws delegates are apportioned to constituent societies and national medical specialty societies at the rate of one delegate per 1000, or fraction thereof, AMA members as of December 31. That is, one must be a member on December 31 to be counted for apportionment purposes. The apportionment is effective January 1 of the following year and is effective for one year. (See bylaws 2.1.1 and 2.2.1 and subsections.) Thus, for example, if a society has 1000 AMA members on December 31, it will be apportioned one delegate for the following year. A society with 1001 members will be apportioned two delegates. (Although they are endorsed by and seated with constituent and national medical specialty societies seated in the House of Delegates, separate bylaws provisions address the regional medical student and sectional resident delegates who are apportioned differently.)

Because of differences in data availability and because delegate apportionment for constituent societies determines the overall delegate apportionment for national medical specialty societies, characterizations below are couched in terms of constituent societies. Figures for those societies are 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.
As written, Resolution 604-A-18 calls for two enumerations of AMA membership, with the first being the usual year-end calculation and the second being a count of members in approximately mid-January. The larger of the two figures would be used for delegate apportionment. Unspecified is who would be counted in the mid-January enumeration. While the count should clearly include those whose current year’s dues have been paid, it should properly exclude individuals who have not paid their appropriate dues by mid-January, as knowing who will (or will not) renew their membership is not possible. A substantial number of members unfortunately do not renew annually, and many members pay their current year dues after mid-January. Given these factors it seems likely that a mid-January count of current year dues paying members would almost certainly be lower than the year end count.

Calculations by AMA’s Membership Group suggest that the magnitude of the difference of the two counts would depend on the date of the second count. The largest number of AMA members is recruited through AMA’s own direct channel, and in any given year the vast majority of current year members have typically joined by February. Consequently, one might advocate for a count in early March or later, but even such a later count would exclude members who join later in the year, particularly the large number of medical students and residents who typically join in summer or fall. Pushing the count to a later date would also shorten the time for societies to adjust their delegation size when necessary.

In light of the ambiguity regarding who would be counted, prior to June’s House of Delegates meeting Georgia, the sponsor of Resolution 604-A-18, proposed that the first resolve would be implemented by counting for apportionment purposes current nonmembers who join the AMA for the succeeding year during the current year. That discussion as well as comments during the reference committee hearing suggested a revision of the first resolve to call for “the number of new AMA members who have already paid their dues for a membership that officially begins on January 1 of the following year will be included in the annual year-end count of AMA members, for the purposes of AMA Delegation entitlements for state and national specialty societies for that following year.” For example, a nonmember in 2018 who during calendar year 2018 joins (and pays dues) for the 2019 membership year would be counted as a member in apportioning delegates for the 2019 calendar year. Hereinafter these are referred to as “pending members,” as their active membership is still pending on December 31.

Whether any particular society would benefit from such a change would depend on whether the inclusion of pending members would carry it over a one thousand threshold. For those societies that gain a delegate, the increased representation would, other things being equal, be a one-time increase. That is because each year some current members choose not to renew their memberships. While they factor into the annual delegate apportionment process as current members, they drop out of the calculations at the end of the subsequent year, and unless the pending members consistently outnumber the non-renewing members, the gain would likely be a one-time event.

Data from year-end 2017, which were used for delegate allocation in 2018, indicate that five states would have gained a delegate this year if pending members had been included. The states that would gain in the future, however, depend on whether the addition of pending members pushes them across the threshold for an additional delegate. For example, only two of the four states currently needing fewer than 100 pending members to gain a delegate position would benefit, while among the 10 states that had the largest number of pending members (range 261–691) at the end of 2017, only the first and third largest would have picked up a delegate. The other three states that would have added a delegate using this method at the end of 2017 did not have the largest number of pending members, but the figure would push them over the additional delegate threshold. In other words, it would be the
combination of pending members and actual members that determines which states would benefit
from the change, adding an element of chance to the apportionment process.

DISCUSSION

Other than changes due to the inclusion of more societies in the House of Delegates (and discounting
freezes), the rules for apportioning delegates to constituent societies have remained essentially
unchanged since 1952. For over a century, the apportionment rules have been based on current
membership, and for seventy years it has been recognized that apportionment should be conducted
annually to address membership fluctuations.

Another issue related to the counting of members warrants further discussion. Counting pending
members, individuals who “join” our AMA at the end of a current year but whose memberships are
not effective until the following year, means that one membership for AMA purposes effectively
counts for two years membership for delegate allocation purposes. In addition, this could result in
the counting members for apportionment purposes that subsequently request a refund and are therefore
never actual dues paying members in either year. Gaming of such a system would be possible, with
for example panels of one-year members joining in alternate years or signing up for membership and
then requesting a refund, which is generally provided upon request in the first half of a calendar year.

Membership accounting can only allocate the membership to the year for which dues are paid, so
membership figures used for apportionment figures that include pending members would be
inconsistent with figures reported in our AMA’s annual report. Both the apportionment figures and
the official membership numbers are publicly available on the AMA website, which would require
the divergent apportionment figures to include an explanatory note. It might also be noted that
adjustments are not made during the year for losses such as deaths, resignations or CEJA actions that
remove an individual from the membership rolls.

While no effort to recruit members to our AMA should be discounted, among current members the
most often cited reason for belonging to our AMA is advocacy on behalf of the profession. This has
been true for many years, and although the value of enhanced representation in the House of
Delegates is often promoted to prospective members, little evidence supports the idea that physicians
join our AMA because of the House of Delegates per se. Rather, the advocacy that stems from House
actions is the more valued commodity. Indeed, the average physician—member or not—knows little
about the House of Delegates and AMA policymaking processes. The prospect of enhanced
representation may be a serviceable argument in the member recruitment quiver, but more successful
appeals address current AMA activities dealing with critical matters of public health, medical
education, practice sustainability and advocacy. Our AMA’s current Members Move Medicine™
campaign is based on this well-established foundation. The current apportionment system occurring at
the end of the year recognizes the recruitment that occurs throughout the year, including the
significant recruitment of medical students and residents that typically occurs well into the year.

Finally, some costs would be associated with the change. Our AMA would incur the expense of
rebuilding the counting procedures and maintaining the distinct records necessary for membership
accounting and apportionment processes. The associated complexity and expense would be greater if
the selected methodology demanded counting pending and current members rather than a simple
change in date of apportionment. Societies in the House of Delegates could incur the intangible cost
of some uncertainty in the number of delegates, which would depend on the counting scheme actually
adopted, along with the real expense of supporting additional delegates. None of these costs are easily
quantified.

RECOMMENDATION
The decision to count pending members for delegate apportionment purposes is clearly within the purview of the House. It would require revisions of the bylaws before it can be implemented with issues of how to handle those who join and those who no longer are AMA members during a calendar year after a fixed point in time of deciding HOD apportionment has occurred. The apparent concern about disenfranchising a new AMA member whose membership is effective after apportionment is readily addressed through the online member forums. With access to online member forums before HOD meetings, that AMA member can have active voice and influence in AMA policymaking.

The House of Delegates has for over a century counted only current members (ie, dues paid and received by AMA) in determining delegate apportionment. The idea that pending members should be added to the current membership seems unwarranted. It effectively double counts individuals, counts members who may or may not rejoin, artificially increases the size of the House of Delegates by including nonmembers in determining representation among Federation societies, and creates opportunities for abuse. Insofar as these pending members will be counted for apportionment purposes for the next cycle when they are actually members, arguments about fairness and representation seem overstated. Finally, under current bylaws any constituent society that may lose a delegate based upon the previous year final count is given a full year to recruit and retain members to retain their delegate count. For these reasons, the Board of Trustees recommends that Resolution 604-A-18 not be adopted and the remainder of this report be filed.

Fiscal note: None

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† 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


*Caring for the Country: A History and Celebration of the first 150 years of the American Medical Association*. American Medical Association, Chicago 1997

INTRODUCTION

At the 2018 Annual Meeting, the House of Delegates referred Resolution 606 as introduced by the delegation from New Jersey to the Board of Trustees, to investigate a proposal that the AMA should “establish a program for training physicians in the art and science of conducting public forums in order to ensure that the public is well informed on the health care system of our country.”

Within the reference committee, there was considerable supportive testimony about the need to improve physicians’ ability to speak publicly. Several who testified believed that the resources needed to undertake training in public speaking are already available throughout the Federation and could be utilized instead of creating new training materials. However, others believed that developing the ability of physicians to positively present themselves in the public arena is too important to leave to other organizations, and that training in public speaking could be offered as a valuable AMA member benefit.

In evaluating the goal and the desired outcome, it is important to survey the existing landscape of resources available to physicians to help inform AMA’s approach.

BACKGROUND

The leading organization that assists individuals with public speaking and leadership development is Toastmasters International. Individuals can improve their speaking and leadership skills by attending one of the 16,400 clubs worldwide. By regularly giving speeches and receiving feedback, individuals can learn to tell their stories and leverage their voices.

AMPAC, the bipartisan political action committee of the American Medical Association, provides high level training to physicians who are considering pursuit of elected office. For those who want to campaign for public office and advocate for issues important to patients and physicians, this is a premiere training program and valuable resource for physicians.

Other general communication resources available by the AMA include STEPS Forward modules on topics like “Conducting Effective Team Meetings” and “Implementing a Daily Team Huddle.”

Within the Federation, several physician groups provide opportunities for training on effective communications, including the American College of Physicians, American Academy of Family Physicians, and the American Medical Women’s Association.
Perhaps the leader in providing this training to physicians is the American Association of Physician Leadership (AAPL). Training topics offered by this organization include: “Present like a Pro,” “Delivering Effective Feedback,” “Fundamentals of Physician Leadership: Communication,” and “Improving Communication and Feedback in Healthcare Leadership.” Courses are offered online or in-person. Many of the self-study courses offer the option to watch the video lectures or attend the sessions. A majority of the courses are accessible for up to three years after purchase. The organization also offers live education courses that allow physicians to network with their peers. There are also faculty-led courses that allow physicians to participate in discussions and case studies throughout a six-week class session.

RECOMMENDATION

Physicians who want to learn more about public speaking can leverage existing resources both within and outside the AMA. AMA can make public speaking tips available through online tools and resources that would be publicized on our website. Physicians and physicians-in-training who want to publicly communicate about the AMA’s ongoing work are invited to learn more through the AMA Ambassador program.

Meanwhile, STEPS Forward provides helpful tips to physicians wanting to improve communication within their practice and AMPAC is available for physicians who want to advocate and communicate about the needs of patients and physicians in the pursuit of public office. There are also resources provided to physicians at various Federation organizations and through AAPL to support those who are interested in training of this nature.

Because public speaking is a skill that is best learned through practice and coaching in a small group or one-on-one setting, we also encourage individuals to pursue training through their state or specialty medical society or through a local chapter of Toastmasters International.

The Board of Trustees recommends that the AMA’s Enterprise Communications and Marketing department work to develop online tools and resources that would be published on the AMA website to help physicians learn more about public speaking in lieu of Resolution 606-A-18 and the 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.
Subject: Women Physicians Section Five-Year Review

Presented by: Alfred Herzog, MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

AMA Bylaw 7.0.9 states, “A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every 5 years that it continues to meet the criteria adopted by the House of Delegates.”

AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is “to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates.”

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

APPLICATION OF CRITERIA TO THE WOMEN PHYSICIANS SECTION

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

The WPS is the only AMA group that is dedicated to advocacy on women physician policy issues, providing leadership development and educational opportunities for women, and monitoring trends and issues that affect women in medicine and women’s health. Currently, the WPS represents more than 82,000 AMA women members. According to 2017 data from the Association of American Medical Colleges, the number of women enrolling in U.S. medical schools has exceeded the number of men. Since 2015, the number of female matriculants has grown by 9.6%, while the number of male matriculants has declined by 2.3%.

The WPS addresses three major concerns: 1) women in medicine professional issues, which include discrimination, e.g., gender bias and income disparity; 2) under-representation of women physicians in leadership positions in organized medicine and academic medicine, which includes disproportionate representation of women physicians in the AMA House of Delegates (HOD); and 3) health issues that disproportionately or uniquely affect women patients.

CLRDP assessment: The mission of the WPS is to provide a dedicated forum within the AMA to increase discussion of and advocacy on women physician issues and strengthen the AMA’s ability to represent this physician constituency. The WPS provides advice and counsel to the Association on policy and program issues of interest to women physicians, and offers suggestions for activities that best meet the needs of this physician segment. No other groups or sections within the AMA specifically address the unique issues of concern of women physicians and patients.
Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the
AMA. Activities make good use of available resources and are not duplicative.

Over the past five years, the WPS has aligned its strategic goals with the AMA to find ways to
promote the efforts of the three strategic arcs. The Section’s educational programs were in
support of topics that highlighted AMA priority issues such as physician burnout, continuing
education, and the opioid epidemic. Overall, the WPS supports the AMA’s objectives by
reviewing new AMA products and services, providing insights on policy and advocacy
positions, and creating new ways to reach out to members and potential members.

The WPS collaborates with other groups to help improve the impact of the Section’s key goals.
During the 2017 Annual Meeting of the HOD, the WPS collaborated with the Medical Student
Section to offer two programs: 1) a session that allowed medical students to connect with WPS
Governing Council (GC) members to discuss such topics as choosing a residency, communicating
with patients, developing leadership skills, critical decision making, careers in academic medicine,
and contract negotiation; and 2) “Occupational Health through a Gender-Conscious Lens.” The
WPS has collaborated with other AMA sections on educational offerings: the WPS, Integrated
Physician Practice Section, and Organized Medical Staff Section program, “Transforming Roles in
Healthcare Leadership: How physicians can effectively communicate with non-physician leaders”;
and the multi-sections’ program, “Gun Violence: What do we know? What can physicians do?”

Additionally, the WPS leads the AMA’s Women in Medicine Month each September. During this
time, the WPS implements two major programs:

1. Inspirational Physicians Recognition Program (formerly the Physician Mentor Recognition
Program). The WPS provides an opportunity for physicians to express appreciation to the
special men and women who have offered time, wisdom and support throughout their
professional journeys.

2. Joan F. Giambalvo Fund for the Advancement of Women (formerly the Giambalvo
Memorial Scholarship Fund). The AMA Foundation in association with the WPS
established the Fund with the goal of advancing the progress of women in the medical
profession, and strengthening the ability of the AMA to identify and address the needs of
women physicians and medical students.

In 2016, the WPS hosted its Women in Medicine Symposium at AMA headquarters, which
included presentations, panel discussions and breakout sessions covering physician resiliency and
burnout, overcoming obstacles in daily practice, and physician wellness techniques.

Over the last five years, the Section has worked collaboratively with various physician groups to
expand the influence of the WPS. Some of these efforts have included strong working relationships
with the leadership of other sections, representation on the AMA Alliance’s Women in Medicine
Task Force, and the renaming and expansion of the liaisons program to the WPS Associates
Program.

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

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

<table>
<thead>
<tr>
<th>Year</th>
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<th>Female</th>
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<tbody>
<tr>
<td>2006</td>
<td>71%</td>
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<td>2014</td>
<td>67%</td>
<td>33%</td>
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<tr>
<td>2016</td>
<td>66%</td>
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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...
Risks (CVD) in Women, and Care of Women and Children in Family Immigration Detention. Eighty-two percent of WPS submitted resolutions resulted in development of new AMA policy or amendment of existing policy. The WPS provides its members with an opportunity to become involved in the Section’s HOD activities, such as delivering testimony on behalf of the Section during reference committee hearings.

Overall, the WPS presents the AMA with the unique policy perspective of its women physician members. The Section brings to the forefront key areas of need in relation to women physicians and women’s health concerns. For example, the WPS introduced and the HOD adopted the resolution, Interventions for Opioid Dependent Pregnant Women (A-16). During the 2017 Annual Meeting, the Section hosted an educational session, “Responding to the Impact of the Opioid Epidemic on Women” and is supporting the efforts of the AMA’s Task Force to Reduce Opioid Abuse. During the 2015 Annual Meeting, the WPS submitted the resolution, Human Trafficking Reporting and Education, that the HOD adopted, and the AMA used to provide testimony for a Congressional Committee.

CLRPD Assessment: The WPS provides numerous opportunities for members of the constituency to introduce issues of concern and participate in the HOD policymaking process. The WPS has continually pursued ways to improve member communications and the resolution process; thereby, encouraging member involvement. The WPS provides a formal structure for women physicians to participate directly in the deliberations of the HOD and impact policy.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Women Physicians Section through 2023 with the next review no later than the 2023 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500
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
04 The Site-of-Service Differential

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
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.
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:
• The drug is for use for a serious condition for which effective treatment is not available in
  the US;
• There is no commercialization or promotion of the drug to US residents;
• The drug does not represent an unreasonable risk;
• The individual importing the drug verifies in writing that it is for personal use, and
  provides contact information for the doctor providing treatment or shows the product is for
  the continuation of treatment begun in a foreign country; and
• Generally, not more than a 3-month supply of the drug is imported.7

The FDA also has utilized its enforcement discretion to allow importation in the case of a shortage
of a prescription drug. In the case of such shortages, when manufacturers of an FDA-approved
prescription drug cannot resolve a shortage immediately, the FDA sometimes has had to turn to
foreign versions of the drug with the same active ingredient manufactured by firms the FDA deems
as reputable and reliable. As a result, the limited importation of the foreign version of the drug has
been allowed until the shortage is resolved.8 Of note, such enforcement discretion has been used
sparingly, including for propofol in 2010 and 2012, ethiodol in 2011 and 2015, methotrexate
injection and liposomal doxorubicin in 2012 and tretinoin capsules in 2016.9

US PHARMACEUTICAL SUPPLY CHAIN INTEGRITY

In the US, the FDA has the authority to ensure the integrity of the US pharmaceutical supply chain,
from raw materials to manufacturing facilities to use by patients. The FDA is undergoing several
initiatives to protect the global prescription drug supply chain, responding to the fact that
approximately 40 percent of finished prescription drugs are imported in the US, and 80 percent of
active pharmaceutical ingredients come from overseas sources. Such initiatives are targeted at
preventing substandard, adulterated and counterfeit drugs from entering the US, and appropriately
communicating risks to patients and providers. The FDA completed 4,936 Good Manufacturing
Practice inspections of registered drug and device establishments in 2017, and issues annual reports
outlining such inspections as well as the percentage of the FDA budget used to fund such
inspections. The FDA also has administrative detention authority to prevent the distribution or
subsequent use of drugs suspected to be adulterated or misbranded at the time of inspection until
the agency determines what action it should take concerning the drugs, including the initiation of
legal action.10,11 In addition, the FDA is working towards fully implementing the Drug Supply
Chain Security Act by 2023. The Act, which was Title II of the Drug Quality and Security Act, was
enacted into law in 2013 and outlines steps to build an electronic, interoperable system to identify
and trace certain prescription drugs as they are distributed in the US.12

CANADIAN REGULATION OF PRESCRIPTION DRUGS AND PHARMACIES

Health Canada reviews prescription drugs to assess their safety, effectiveness and quality before
they are authorized for sale in Canada, and performs continuous evaluations after such drugs are on
the market, including monitoring adverse reactions. Once approved for sale, prescription drugs in
Canada are issued an eight-digit Drug Identification number, which indicates that Health Canada
considers the drug safe and effective, and provides a mechanism to track adverse reactions. Also,
Health Canada licenses and conducts inspections of pharmaceutical manufacturers, importers and
distributors. In order to prevent unauthorized drug products from entering Canada, including
counterfeit and adulterated drugs, Health Canada works in cooperation and coordination with the
Canada Border Services Agency.13,14 The FDA has voiced its confidence in Health Canada in
providing effective oversight of drugs approved for use by Canadian patients.15
There are 10,947 licensed pharmacies in Canada, including 10,463 community pharmacies. Provincial and territorial pharmacy regulatory authorities regulate the practice of pharmacy and the operation of pharmacies in their respective jurisdictions in Canada. This includes the licensing of pharmacies in Canada, including traditional “brick-and-mortar” pharmacies and storefront pharmacies that conduct business online.

RELEVANT ADMINISTRATIVE AND LEGISLATIVE ACTIVITY

In response to the request of HHS Secretary Alex Azar in July 2018, a work group will assess how to safely import prescription drugs from other countries under certain narrow circumstances not involving a shortage, namely in the event of a significant price increase for a prescription drug that is only produced by one manufacturer and not protected by patents or exclusivities. The FDA Commissioner has stressed that if drugs that fall under this categorization can be imported in a manner that ensures safety and effectiveness, such importation would be temporary until there is sufficient competition.

In addition, legislation has been introduced to permit prescription drug importation. Legislative approaches to prescription drug importation vary in many respects. For example, while some bills focus on the importation of prescription drugs from Canada, therefore requiring the Secretary of HHS to promulgate the necessary regulations on this issue, other bills could potentially allow prescription drug importation from additional countries that meet standards for ensuring the safety and effectiveness of drugs that are at least as protective as such standards in the US. Bills also vary in defining the foreign pharmacies and entities from which individuals can import prescription drugs.

Senator John McCain (R-AZ) and Congresswoman Chellie Pingree (D-ME) have introduced S 64/HR 1480, the Safe and Affordable Drugs from Canada Act of 2017. S 64/HR 1480, if enacted into law, would compel the HHS Secretary to promulgate regulations within 180 days permitting individuals to import a prescription drug purchased from an approved Canadian pharmacy that: is dispensed by a pharmacist licensed in Canada; is purchased for personal use in quantities not greater than a 90-day supply; is filled using a valid prescription issued by a physician licensed to practice in the US; and has the same active ingredients, route of administration, dosage form, and strength as a prescription drug approved under the Federal Food, Drug, and Cosmetic Act. The legislation does not authorize importation of certain medications, including controlled substances and biological products. The bill establishes a certification process for approving Canadian pharmacies and HHS would have to publish a list of approved Canadian pharmacies. Senator McCain also introduced S 92, legislation with the same title and most of the same text as S 64, but differing in that it would give HHS 185 days to promulgate regulations permitting individuals to import a prescription drug purchased from an approved Canadian pharmacy instead of 180 days.

Congressman Keith Ellison (D-MN) has introduced HR 934, the Personal Drug Importation Fairness Act of 2017. If enacted into law, the legislation would allow a drug to be imported by a person other than the drug’s manufacturer if the drug has the same active ingredients, route of administration, and strength as an approved drug. The bill also states that drugs could be imported or reimported from the following countries if the FDA determines that they have standards for ensuring drug safety and effectiveness that are at least as protective as US standards: Australia, Canada, Israel, Japan, New Zealand, Switzerland, South Africa, a member-state of the European Union, or a country in the European Economic Area. Prescription drugs to be imported would be required to be dispensed by a licensed pharmacist; be shipped directly to, or imported by, the ultimate consumer; and shipped or imported in quantities that do not exceed a 90-day supply. The bill would prohibit the importation of controlled substances.
Senator Bernie Sanders (I-VT) and Congressman Elijah Cummings (D-MD) have introduced S 469/HR 1245, the Affordable and Safe Prescription Drug Importation Act. If enacted into law, the legislation would require HHS to issue regulations within 180 days allowing wholesalers, licensed US pharmacies, and individuals to import qualifying prescription drugs manufactured at FDA-inspected facilities from licensed Canadian sellers. After two years, the Secretary would have the authority to permit importation from countries in the Organisation for Economic Co-operation and Development that meet specified statutory or regulatory standards that are comparable to US standards. The bill would prohibit the importation of controlled substances, anesthetic drugs inhaled during surgery, and compounded drugs. The bill stipulates that an individual may import a qualifying prescription drug for personal use in quantities not greater than a 90-day supply from an online pharmacy or by a certified foreign seller that is a licensed foreign pharmacy. The bill also would require that individuals importing qualifying prescription drugs must provide to the licensed foreign pharmacy a valid prescription issued by a health care practitioner licensed to practice in the US.

There also has been state activity in the arena of prescription drug importation. Nine states have introduced drug importation legislation this year, with Vermont enacting a law that would allow drug importation from Canada through authorized wholesalers. The state is required to submit a drug importation proposal for federal approval. Without federal approval, Vermont’s law will face the same fate as Maine’s, which was enacted in 2013 to allow its citizens to import prescription drugs from Canada, New Zealand, Australia, and the United Kingdom. However, in 2015, a federal district court ruled that Maine’s law was unconstitutional, as federal law preempts state law on this issue.

DISCUSSION

Supporting the ability of US patients to purchase and import prescription drugs in-person from a licensed Canadian pharmacy has the potential to improve patient cost-sharing levels if significant cost savings could be achieved, which would positively address one barrier to medication adherence. The Council notes that under such a policy, some patient medications, including controlled substances and biologicals, may not be allowed to be imported. Nevertheless, the Council believes that a risk to patients who pursue the importation of prescription drugs from Canada remains, especially those who import such drugs via the Internet which increases the risk of receiving substandard, adulterated and counterfeit drugs.

Policy D-100.983 provides a strong, balanced approach to guide the support of our AMA for the legalized importation of prescription drug products by wholesalers and pharmacies, as well as the personal importation of prescription drugs via the Internet. Critically, the policy predicates AMA support for prescription drug importation on ensuring that safety concerns with imported prescription drugs are addressed, to ensure that they are of the same quality and chemical makeup as those currently distributed in the US. While in-person importation from licensed pharmacies in Canada may face fewer safety concerns than importing prescription drugs via the Internet which would then be shipped to patients, ensuring the safety of such imported drugs must remain a priority. Therefore, the Council recommends that our 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. The Council also believes that the FDA needs new and additional resources to administer and enforce a program that allows the in-person purchase and importation of prescription drugs from 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
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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.
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. 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. 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.
It is estimated that more than 550,000 patients in the US use air ambulance services every year. Further, air ambulance services have increased significantly in recent years. In 2002, there were about 400 air ambulances in use across the US, and that number more than doubled to over 800 air ambulances by 2008. This increase in the number of air ambulances has sparked criticism from consumer groups of oversupply and contributing to the overuse of air ambulance services that may not be medically necessary. It is estimated that nearly a third of patients transported via air ambulance helicopter were minimally injured. In addition to possible unnecessary use of air ambulances, other reasons for the growth in the industry include an aging population, a decrease in the number of emergency departments in hospitals, and changes in health care delivery in rural settings.

Air ambulances have emerged as one solution to the problem of rural health care facility closures. A quarter of Americans, or 85 million people, are estimated to be unable to access health care in less than an hour of travel time without an air ambulance, and such ambulances may be the only viable means of transporting patients to the care center they need. However, over the past decade, many states have reported issues with air ambulance providers who are not affiliated with any hospital or insurance carrier.

AIR AMBULANCE BUSINESS MODEL

Air ambulance providers generally function in one of three business models based on the entity that owns the air ambulance and the individuals providing medical services aboard the aircraft. The first model is a hospital-based model wherein the hospital provides medical services and staff and typically contracts with third parties for the pilots, aircraft, and maintenance. The second model is the independent model wherein operations are not controlled by a specific medical facility. Independent models may consist of for-profit or non-profit providers who directly employ the medical and flight crews to provide services. The third model is the government model where a state, municipal government, or military unit owns and operates the air ambulances.

Until 2002, air ambulances were primarily owned and operated by hospitals. However, in 2002, Medicare created a national fee schedule for air ambulances based on a thorough investigation into the “reasonable cost” for emergency medical services (EMS). The national fee schedule had the effect of increasing the Medicare reimbursement rate for helicopter air ambulance transport and in particular raising the rate of payment for rural air transports.

Due in part to the establishment of the fee schedule, for-profit companies established and expanded their air ambulance businesses. Currently, it is estimated that more than half of the air ambulance industry is controlled by four for-profit air ambulance operators. The doubling of the number of air ambulances since 2002 potentially may be attributed to the closure of clinics and hospitals in rural areas.

COST AND COVERAGE OF SERVICES

Patients typically have little to no choice over the service or provider of an air ambulance due to the urgent nature of the transports. Furthermore, air ambulance providers generally do not turn away patients based on their ability to pay and garner payments from patients’ insurance companies. Air ambulance providers typically charge standard rates based on an established lift-off fee and per mile fee for all transports and receive payments from various sources at differing rates depending on a patient’s insurance coverage. Further, the amount paid by private health insurance hinges on whether the air ambulance provider participates in a contract with the private insurer.
Depending on insurance coverage, patients can be billed for air ambulance charges that have potentially significant financial consequences. Costs for the average air ambulance trip run in the tens of thousands of dollars. According to the Centers for Medicare & Medicaid Services (CMS) and private health insurance data, between 2010 and 2014, the median prices providers charged for air ambulance service doubled from about $15,000 to about $30,000 per transport.9 According to numerous air ambulance providers, privately insured patients account for the largest percentage of their revenue. The median payment that three large national private insurers paid per air ambulance transport increased from about $15,600 to $26,600 from 2010 to 2014, an increase of 70 percent. With insurers under pressure to cut costs, they have been reducing payments for air ambulances.10

Although air ambulances account for less than one percent of total ambulance claims, they represent about eight percent of Medicare spending on ambulance services due to their significant cost. Air ambulance providers are not permitted to balance bill Medicare and Medicaid patients beyond deductibles and coinsurance requirements. Patients with private insurance may be balance billed only if the air ambulance provider is out-of-network. Patients without insurance may be billed for the total price of the air ambulance bill. Due to a lack of information, it is unclear to what extent air ambulance providers balance bill.

Numerous factors likely contribute to the high costs of air ambulance services, including the price and maintenance of the necessary equipment and employment of specialized medical personnel around-the-clock. In order to stay in operation, air ambulance providers must earn revenue sufficient to cover their costs. The median cost per base for independent air programs is almost $3 million, with 77 percent of the costs incurred being fixed costs associated with operating a base.11 To increase revenue, air ambulance providers need to increase the number of transports or the cost charged per transport. According to eight air ambulance providers, the average cost they incurred per transport is between $6,000 to $13,000.12

A more thorough look into the factors affecting air ambulance pricing is not possible due to lack of data. For example, the cost incurred by air ambulance providers to provide service is not readily available, and there is no national database with this information. Moreover, there are no data available that address cost differences of air ambulance service capabilities and how cost is affected not only by transport but also service level. In addition, available data are insufficient to discern the prices charged by air ambulances, charges across various air ambulance business models, and charges to individuals with varying coverage statuses. The lack of systematic data collection makes it impossible to determine the market share of particular air ambulance providers and corresponding price information.

LEGISLATIVE ACTIVITY

Though some states have attempted to create consumer protections from costly air ambulance bills, federal preemption has largely prevented state regulation. The Airline Deregulation Act (ADA) of 1978 prohibits states from regulating the price, route, or service of an air carrier for the purposes of keeping national commercial air travel competitive.13 The ADA applies to air carriers that provide air ambulance services and are, therefore, protected from state attempts to regulate their price, route, and service. Accordingly, air ambulance providers generally are not subject to the price competition that usually occurs in competitive markets wherein high prices will lead consumers to find lower-cost alternatives.
In contrast to air ambulances, ground ambulances are regulated under the Affordable Care Act (ACA) and applicable state laws. 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. 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. That our American Medical Association (AMA) amend Policy, H-130.954, “Non-Emergency Patient Transportation Systems,” by addition as follows:
   The AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients. (Modify Current HOD Policy)

2. That our AMA support increased data collection and data transparency of air ambulance providers and services to the appropriate state and federal agencies, particularly increased price transparency. (New HOD Policy)

3. That our AMA work with relevant stakeholders to evaluate the Airline Deregulation Act as it applies to air ambulances. (New HOD Policy)

4. That our AMA support stakeholders sharing air ambulance best practices across regions. (New HOD Policy)

5. That our AMA rescind Policy D-130.964, which directed the AMA to conduct the study herein. (Rescind AMA Policy)

Fiscal Note: Less than $500.
REFERENCES


3 Supra note 1.


7 Supra note 1.


9 Supra note 1.

10 Id.


12 Supra note 1.


14 Id.

15 Id.
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.
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. 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.

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. 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, 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. 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>
<thead>
<tr>
<th>Site</th>
<th>Physician Office</th>
<th>Hospital Outpatient Department</th>
<th>Ambulatory Surgical Center</th>
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<tbody>
<tr>
<td><strong>Payment System</strong></td>
<td>Physician fee schedule (non-facility rate)</td>
<td>Physician fee schedule (facility rate) plus OPPS rate</td>
<td>Physician fee schedule (facility rate) plus ASC payment system (based on relative weight under the OPPS)</td>
</tr>
<tr>
<td><strong>Basis for Updates</strong></td>
<td>Medicare Access and CHIP Reauthorization Act (MACRA)</td>
<td>Hospital market basket</td>
<td>Consumer price index for all urban consumers</td>
</tr>
<tr>
<td><strong>Unit of Payment</strong></td>
<td>Individual service</td>
<td>Ambulatory payment classification</td>
<td>Ambulatory payment classification</td>
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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. 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. 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.

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. 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. 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. Many physician practices also provide high-technology outpatient...
services (ie, infusions and/or imaging) that were once the domain of hospitals and for which practices are not adequately compensated under the PFS.

Hospitals that treat a disproportionate share of low-income patients receive additional payments to offset the financial effects of treating these patients. Traditionally, disproportionate share hospital (DSH) payments were based on hospitals’ share of Medicaid patients and Medicare patients with Social Security Disability Insurance. Beginning in 2014, DSH payments were calculated as 25 percent of that payment amount, and hospitals also began receiving uncompensated care payments from a pool of funds equal to 75 percent of the DSH payment received under the traditional formula, minus an amount that increases in proportion to decreases in the uninsured population. Part of this pool is distributed to hospitals based on the share of uncompensated care they provide. Physician practices are not eligible for either DSH or uncompensated care payments, despite the fact that most physicians (89 percent) treat Medicare patients and, in 2016, most also had Medicaid (82.6 percent) and uninsured (75.6 percent) patients. There have been questions as to whether Medicare DSH and uncompensated care payments are appropriate proxies for the amount of uncompensated care provided by hospitals, and Medicare Payment Advisory Commission (MedPAC) has recommended that uncompensated care payments to hospitals be based on actual uncompensated care data.

Expert Policy Recommendations for Reducing Payment Variations

To address shifts in outpatient care to higher cost sites-of-service (eg, hospital-owned facilities), which increase costs to the Medicare program and its patients, several policy options have been proposed to equalize payments across settings for certain services. After the MedPAC found that payments to HOPDs for 15-minute evaluation and management visits were 80 percent higher than payments to physician offices for the same service, it recommended in 2012 that HOPD payments for these services be reduced to physician office rates. In 2014, MedPAC recommended that differences in payment rates between HOPDs and physician offices be eliminated by reducing HOPD rates for 66 ambulatory payment classifications. These groups of services were selected by MedPAC based on patient severity being similar in HOPDs and physician offices, and because they are frequently furnished in physician offices.

A 2011 RAND Health analysis examined several policy options for addressing Medicare payment differentials across outpatient sites, such as increasing uniformity in the units of service across payment systems, and basing payment rates on the least costly setting. This analysis concluded that basing payment differentials on justifiable cost differences would promote payment equity across outpatient sites-of-care and value-based care, but would also be administratively burdensome. Determining justifiable cost differences would also be impractical.

The Office of the Inspector General (OIG) has also recommended reductions in HOPD payment rates to those of less costly settings, and has even recommended pursuing legislative changes to OPPS budget neutrality provisions so that payment rates to HOPDs could be reduced without offsetting those reductions with payment increases. Several administrations have also proposed equalizing payment variations via budget proposals, and President Trump’s budget published in February 2018 proposed applying physician office rates to all hospital-owned physician offices located off the hospital campus. As stated previously, CMS has proposed extending site-neutral payments to include clinic visits provided at off-campus hospital-owned facilities.

It is clear that most of the policy options identified to date have recommended leveling the site-of-service playing field by reducing payment rates to the amounts payable in the least costly 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 OPPS 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 OPPS.

**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 OPPS 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. 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.

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 OPPS 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. As described in the following section, survey data are used by CMS to determine the indirect practice expenses...
incurred per hour worked. 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. 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.

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.” 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-
coverage of services. Since the passage of MACRA, the AMA has been accelerating its efforts to help national medical specialty societies and other physician organizations to develop, refine and implement alternative payment models (APMs) that will achieve these goals. Ideally, payment under these models should extend across sites of care.\footnote{AMA policy (Policy H-385.913)} recognizes that APMs should provide adequate resources to support the services physician practices need to deliver to patients. The AMA has urged the US Department of Health and Human Services to reconsider testing a number of APMs as recommended by the Physician-Focused Payment Model Technical Advisory Committee.\footnote{AMA policy (Policy D-330.997)}

**Improving Price Transparency**

As the health care market evolves, patients are increasingly becoming active consumers of health care services rather than passive recipients of care in a market where price is often unknown until after the service is rendered. Achieving meaningful price transparency can help lower costs and empower patients to make informed care decisions, including decisions about where to receive certain outpatient services. Many patients may not be able to readily distinguish between hospital-owned and independent practices, and may not understand how choice of outpatient setting impacts their cost-sharing expenses. The AMA supports measures to expand the availability of health care pricing information that allows patients and their physicians to make value-based decisions when patients have a choice of provider or facility.

**DISCUSSION**

The AMA has long supported and advocated for fair, equitable and adequate Medicare payments across outpatient sites of service, as well as payment policies that support value-based care and encourage use of the most cost-effective care setting. The policy priority established by the Council in previous reports addressing the site-of-service differential has been to ensure patient access to services in the most clinically appropriate setting, depending on their needs and the severity of their conditions. While an HOPD may be the appropriate setting for certain medically complex patients, the migration of many services from physician offices to hospital-owned facilities is of significant concern not only because of increased costs to the Medicare program, but also because it has become increasingly difficult for practices in certain specialties to remain competitive or even sustain operations because of declining payment rates and the increased costs to practices of dealing with regulatory and administrative burdens. The Council continues to be concerned for independent physician practices, and for Medicare patients who incur higher cost-sharing expenses for outpatient services provided in hospital facilities whose care could have been safely provided in lower-cost settings. The Council believes that policy proposals addressing the site-of-service differential must be patient-centric and ensure adequate payment that supports the costs of providing high-quality, high-value physician services.

Accordingly, the Council recommends reaffirming four existing policies that guide AMA advocacy regarding the site-of-service differential: Policy H-240.993, which calls for equity of payment between services provided by hospitals and similar services provided in physician offices; Policy D-330.997, which supports defining Medicare services consistently across settings and encouraging CMS to adopt payment policies that assist in leveling the playing field across all sites of service; Policy H-400.957, which encourages CMS to expand the extent and amount of payment for procedures performed in physician offices, to shift more procedures from the hospital to the office setting, and to seek to have practice expense RVUs reflect the true cost of performing office procedures; and Policy H-400.966, which promotes the compilation of accurate physician practice cost data as the basis for informed and effective advocacy concerning Medicare physician payment.
Building on these policies, the Council recommends that the AMA support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. This policy recommendation enables ongoing AMA advocacy in support of site-neutral payments while at the same time seeking solutions that do not simply lower payments for services to amounts paid to the least costly setting. The Council is mindful that there is the potential for physicians to be adversely affected as Congress and the Administration promote site-neutrality based solely on cost as a means of reining in health care spending.

The site-of-service differential impedes the provision of high-value care because it incentivizes payment based on the location where a service is provided. Payment should be based on the service itself, and not the location where it is provided. Accordingly, the Council recommends that the 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.

After extensive exploration of the “combined health care payment system” described in the second resolve of Resolution 817-I-17, the Council concludes that the practice expense component of the PFS is analogous to the facility fee paid under the OPPS, and that the valuation of the practice expense component needs to be updated to accurately reflect the costs of running a practice. The Council further believes that if physicians are paid a facility fee as called for in the second resolve, that fee is likely to be smaller than the current one and might not make up for the probable elimination of the practice expense differential in the current system. Rather than seeking the statutory changes to implement a combined payment system that pays facility fees for both hospital-owned and independent physician practices—which would be extremely challenging to accomplish in a Congress hamstrung by partisanship and a trillion-dollar deficit—the Council recommends urging CMS to update the data used to calculate the practice expense component of the PFS. The Council believes that CMS should conduct a survey similar to the PPI Survey to confirm the accuracy of practice expense data, given the many changes that have occurred since the survey was administered in 2007 and 2008, and that this survey should be administered every five years to ensure that timely data are used to inform PFS calculations. The Council believes that CMS should collect data to ensure that all physician practice costs are captured. Examples of data that must be collected by CMS include administrative and other costs that cannot be directly attributed to a service, costs of managing the practice, costs of providing uncompensated care, costs of navigating payer protocols and utilization management requirements, costs of purchasing, managing and updating EHRs, and costs related to quality measures and improvements.

Advocating for regular ongoing collection of physician practice expense data that more accurately reflect the costs of sustaining a practice is a viable option that could be impactful in the nearer term although, under Medicare’s current system, PFS payments would be redistributed rather than increased overall. The updated data could be used to help measure differences in the costs of providing services in physician offices and hospital settings, and would inform future AMA advocacy on broader payment reforms.

To address concerns regarding the methodology used for DSH and uncompensated care payments to hospitals and the care provided by many physicians for which they are not fully compensated, the Council recommends that the AMA encourage CMS to both: a) base DSH and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care.

While the focus of this report is the site-of-service differential, the Council recognizes the need to 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)
8. That our AMA encourage CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care. (New HOD Policy)

9. That our 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. (Directive to Take Action)

Fiscal Note: $100,000 to $200,000
REFERENCES


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.


10 Ibid.


16 Ibid.


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.
27 Ibid.
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

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.

(Final HOD Policy)

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

Date Received: 9/21/18

RELEVANTAMA 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
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). 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 upside 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
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)

Whereas, “Dense breast” tissue makes it harder to identify cancer on a mammogram, especially if there are no calcifications present within the cancer; and

Whereas, Patients with “dense breast” tissue are also associated with an increased risk of breast cancer (i.e., the risk is estimated to be four times greater for women with extremely dense breasts versus women with fatty breasts); and

Whereas, A “negative” screening mammography result does not reliably rule out cancer in women with dense breasts; and

Whereas, These women with “dense breast” tissue often have higher stage cancers upon detection due to the fact that they are not discovered until they are larger and symptomatic; and

Whereas, Ultrasound and MRI have been shown to reduce interval cancers in women with “dense breasts”; and

Whereas, Approximately 30 states have adopted laws requiring notification to patients with “dense breasts”; and

Whereas, The decision to pursue additional screening should be a result of the conversation between individual patients and their physician-led health care team; and

Whereas, Insurance companies are not required to pay for additional screening; therefore be it

RESOLVED, That our American Medical Association support insurance coverage for supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for insurance coverage for and adequate access to supplemental screening recommended for patients with “dense breast” tissue following a 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)

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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
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.
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)
Reference Committee K

BOT Report(s)

12  Information Regarding Animal-Derived Medications

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
INTRODUCTION

Resolution 515-A-18, “Information Regarding Animal Derived Medications,” introduced by the Michigan Delegation and referred by the House of Delegates (HOD) asked:

That our American Medical Association (AMA): (1) Support efforts to improve cultural awareness pertaining to the use of animal-derived medications when considering different prescription options. (2) Encourage the U.S. Food and Drug Administration to make available to the public an easily accessible database that identifies medications containing ingredients derived from animals.

Some chemical products used as inactive excipients for prescription drugs, as well as some active prescription medications and also some surgical implants, dressings, and mesh, are derived from animal sources. The consumption or use of such products may be objectionable to certain religions or based on consumer choice. The objective of this report is to summarize the issue and current evidence related to animal-derived components of medical products.

BACKGROUND

Some religious faiths forbid the consumption or use of certain animals and substances derived from them. Additionally, individuals who adhere to a vegetarian or vegan diet may prefer to avoid animal-derived medical products. Individuals who want to avoid animal-derived substances for religious or cultural reasons may inquire about the origin or source of the ingredients in their medical products for informed decision-making regarding treatment with the product. Frequently, however, the information regarding ingredients or composition in medications is difficult to obtain by physicians, pharmacists, and patients.¹

Many pharmaceutical products (both active and inactive ingredients used in capsules, tablets, injections, vaccines, creams) and surgical products (implants, wound dressings, surgical mesh) contain ingredients derived from animal sources. Animal-derived ingredients (ADIs) are used in many medical fields and cover an array of products usually at minimal concentrations.¹ However, a substantial percentage of patients and physicians are unaware that some medications and medical products contain animal products;² one survey indicated that 84% of patients and 70% of physicians were unaware that several medications contain ADIs. Additionally, 70% of physicians thought it was important to inform patients who might object if such medications are prescribed.³ Some authors have even suggested obtaining informed consent before using animal-derived 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. 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).

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.

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.

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. 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.
It has been documented that physicians may have a hard time determining the origin of ingredients because the information is inconsistently reported, difficult to obtain, and sometimes incorrect. Many times, reading the list of ingredients of a medical product will not clarify if the product contains any animal-derived ingredients or components. Additionally, the products can vary in regard to ADIs based on the manufacturer, and between brand name and generic versions.

Because no requirement exists for a manufacturer to declare how an ingredient is sourced on label information, this information is not present in clinical decision support systems for physicians and drug databases. Including additional information, such as the presence of ADIs and their source, in the ingredients lists on drug labels and in product information would be beneficial because this information could then be included in information systems used by clinicians and would be more accessible to patients.

RECOMMENDATION

The Board of Trustees recommends the following be adopted in lieu of Resolution 515-A-18, and the remainder of the report be filed:

Animal-Derived Ingredients

Our AMA:

1. Urges the U.S. Food and Drug Administration to require manufacturers to include all ingredients and components present in medical products on the product label, including both active and inactive ingredients, and denote any derived from an animal source. (New HOD Policy)

2. Encourages cultural awareness regarding patient preferences associated with medical products containing active or inactive ingredients or components derived from animal sources. (New HOD Policy)

Fiscal Note: Less than $500
REFERENCES


4. 21 U.S.C. ch. 9 § 301.


7. 21 C.F.R. pt. 201


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

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¹ AMA Code of Medical Ethics Opinion E-7.2.1 Principles for Disseminating Research Results
³ AMA Code of Medical Ethics Opinion E-7.1.3 Study Design and Sampling
RESOLVED, That our American Medical Association support preregistration in order to mitigate 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.

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.\(^1\)^ 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.\(^2\)^ 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.\(^3\)^ 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.\(^4\)^ 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.\(^5\)^ 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.\(^6\)^ 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.\(^7\)^ 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.\(^8\)^ and

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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.

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.


**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)
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\(^1\); and

Whereas, Research demonstrates that consumers will exhibit a preference for a product with a FOP nutrient claim regardless of its qualitative value\(^3\); and

Whereas, Studies show that children perceive food products with nutrient claims on their FOP label as healthier\(^4\); 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

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Whereas, Evidence shows that individuals who consume diets high in refined carbohydrates are at a greater risk of becoming obese\textsuperscript{10}, developing diabetes\textsuperscript{11}, and dying from a cardiovascular event\textsuperscript{12}; 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 claim\textsuperscript{13}; 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\textsuperscript{14,15,16}; and

Whereas, Standardized warning labels have been mandated in Chile on food products high in sugar, salt, fat, and calories since 2016\textsuperscript{17}; 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 calories\textsuperscript{18}; and

Whereas, Chilean consumers purchase more of the foods without warning labels than they did before implementation of the warning labels\textsuperscript{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


\textsuperscript{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).


\textsuperscript{17} Carreño, I. (2015). Chile’s Black STOP Sign for Foods High in Fat, Salt or Sugar. European Journal of Risk Regulation, 6(04), 622-626. doi:10.1017/s1867299x0000516x


RESOLVED, That our American Medical Association support additional U.S. Food and Drug Administration criteria that limit the amount of added sugar a food product can contain if it carries any front-of-package label advertising nutritional or health benefits (New HOD Policy); and be it further

RESOLVED, That our AMA support the use of front-of-package warning labels on foods that 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
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

² Next Generation 9-1-1 Advancement Act of 2011, 47 U.S.C §158. (2012)
¹¹ 911 service, 47 C.F.R. § 20.18(h) (2012).
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;¹⁶ 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


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 exposer is unknown;¹¹,¹² and

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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;\textsuperscript{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;\textsuperscript{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\%;\textsuperscript{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;\textsuperscript{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;\textsuperscript{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;\textsuperscript{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;\textsuperscript{22,23,24} and


\textsuperscript{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.

\textsuperscript{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.


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;\textsuperscript{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;\textsuperscript{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:

\textbf{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

\textbf{RELEVANT AMA POLICY:}

\textbf{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 that patients who are identified as HIV positive to cease endangering others.


\textsuperscript{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.

(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/CLRDP 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
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

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; 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; 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; 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; 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; and

Whereas, The average application fees to obtain a birth certificate and passport in the U.S. are $15.81 and $97, respectively; and

Whereas, A national study found that 36% of homeless individuals could not obtain a photo identification because they could not afford it; 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, therefore be it


RESOLVED, That our American Medical Association recognize that among the homeless population, lack of identification serves as a barrier to accessing medical care and fundamental services that support health (New HOD Policy); and be it further

RESOLVED, That our AMA support legislative and policy changes that streamline, simplify, and reduce or eliminate the cost of obtaining identification cards for the homeless population. (New 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)
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

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”;⁵ 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;¹⁷ 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;¹⁴ 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

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¹ Alameda County Board of Supervisors. Legislative Position Request Form. January 11, 2016.
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.

**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
Whereas, Almost a fourth of men and women between the age of 18 and 50 currently have a tattoo; and

Whereas, The Food and Drug Administration regulates cosmetics, which are generally pigments used on the surface of the skin, but does not regulate tattoo and permanent makeup inks which are pigments injected with needles below the skin’s surface; and

Whereas, Some risks, such as the spread of infections through the use of unsterilized needles, have long been known; and

Whereas, The long term safety of permanent tattoo inks has not been previously studied; and

Whereas, Research has also shown that some pigment migrates from the tattoo site to the body’s lymph nodes; and

Whereas, Many pigments used in tattoo inks are industrial-grade colors suitable for printers’ ink or automobile paint; and

Whereas, Azo pigments, the organic pigments making up about 60% of the colorants in tattoo inks are not of health concern while chemically intact, they can degrade with the help of bacteria or ultraviolet light and potentially can turn into cancer-causing primary aromatic amines; and

Whereas, Some surveys show that up to 50% of tattoo owners come to regret getting a tattoo; and

Whereas, Lasers are often used to blast apart pigments, sending problematic degradation products into the body and researchers do not know how the degradation products are distributed in the body or how they get excreted; and

Whereas, A study by the Australian government’s National Industrial Chemical’s Notification and Assessment Scheme (NICNAS) showed the presence of polycyclic aromatic hydrocarbons (PAHs), a group of chemicals known to be carcinogens in more than one-fifth of 49 inks tested and in 83% of the black inks tested; and

Whereas, Tattoo inks may also contain potentially harmful metal impurities such as chromium, nickel, copper, and cobalt; and

Whereas, Manufacturers of tattoo and permanent makeup inks in the United States are often protected from divulging the ingredients of tattoo inks under the guise of considering them ‘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 durability, 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 contents; 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:
2. https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm048919.htm
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)
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-being\(^1\); 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)

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/CLRDPD Rep. 3, A-14
Whereas, Pornography is now recognized as a factor that directly contributes to and increases all forms of violence against women as well as violence against children\textsuperscript{1-17}; and

Whereas, Exposure to pornography has been demonstrated to increase the likelihood of perpetration of violence, including rape, domestic violence, and sexual harassment\textsuperscript{1-17}; and

Whereas, Literature shows that pornography demonstrably teaches beliefs about women, children, and interpersonal relationships and teaches pathological and/or illegal sexual behaviors (including rape, child molestation, prostitution, domestic violence, pedophilia, sexual harassment, and some paraphilias)\textsuperscript{4-7}; and

Whereas, Data demonstrate that pornography normalizes and promotes these pathological and/or illegal behaviors\textsuperscript{1-3, 18-23}; and

Whereas, Digital access allows average age of first pornography exposure in the early teens during a crucial stage of sexual development in young people\textsuperscript{8-17}; and

Whereas, Pornography can also promote behaviors that increase the risk of sexually transmitted diseases, gastrointestinal fissures/ruptures, post-traumatic stress disorder, sex addiction, and paraphilias\textsuperscript{18-23}; and

Whereas, Four states (Florida, Idaho, Kansas, and Utah) have declared pornography to be a public health risk\textsuperscript{24}; therefore be it

RESOLVED, That our American Medical Association support efforts to mitigate the negative public health impacts of pornography as it relates to vulnerable populations, including but not limited to women and children. (New HOD Policy)

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

Received: 09/28/18
References:


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.

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
Whereas, In the last few decades the United States has achieved remarkable success in reducing the use of tobacco products and the associated negative health consequences; and

Whereas, From a common sense perspective, most would agree that in the case of an individual smoking tobacco vs. e-cigs, the tobacco smoke produces more harmful tars and toxins and individuals have the right to try to switch to e-cigs to reduce inhaling these; and

Whereas, Many physicians believe that because of the addictive - and possible acute inflammatory effects of nicotine on the cardiovascular system - patients be encouraged to try to stop smoking by other means before using e-cigs; and

Whereas, Teens and young adults, up to 21 years of age should avoid all nicotine delivery products because of the risks of addiction and adverse effects on brain development; and

Whereas, The strong divide in the medical and public health communities regarding accessibility of e-cigs, primarily rests on “population” based disagreements and speculations regarding whether they are effective for the complete abstinence from smoking cigarettes, will prove effective over the long term in reducing tobacco use and whether they play a role in addicting youth to nicotine, and possibly tobacco; and

Whereas, Recent debate over the role of inhalation products in further tobacco harm reduction has created confusion within the profession and public, rather than the sage guidance they deserve; and

Whereas, E-cigarettes have been shown to be effective in reducing tobacco use in some adults justifying them as a cessation option, yet, it is also prudent to assure minors are banned from purchasing potentially addictive nicotine substances; and

Whereas, Although abstinence of inhalation of other than prescribed drugs is the healthiest practice, youth continue to experiment with inhalation of substances such as cannabis, corn silk, hookah mixtures and non-drug containing, relatively toxic free, often flavored, “vape” products; and therefore be it
RESOLVED, That our American Medical Association advocate for a “protect adult choice and youth’s health” “common sense” tobacco strategy (with a report back to the House of Delegates annually) under which:

- Current educational, promotional and policy initiatives (e.g. taxation) to reduce the use of tobacco products by inhalation and orally would continue, including advocating for the prohibition of the sale of ALL nicotine containing products to individuals under 21 years unless via prescription for medical purposes.

- E-cigarettes (non-tobacco products containing nicotine) would be accessible at an affordable price to adults who wish to use them, and would be available to individuals below 21 years of age only as part of state sanctioned tobacco cessation activities. States and local jurisdictions would be free to require vendors to post warnings regarding the possible health risks of the use of nicotine inhalation products.

- Non-nicotine, non-drug containing vaping and other inhalation products would not be considered tobacco products, but would be monitored by state and local jurisdictions as any other personal use product regarding safety and public accommodation. (New HOD Policy)

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

Received: 09/28/18
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

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
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
in the U.S. District Court for the District of Columbia alleging that changing the definition of
employer is inconsistent with the ACA and is a violation of the Administrative Procedures Act.

• The Centers for Medicare & Medicaid Services (CMS) announced on July 7, 2018, a delay of
ACA risk adjustments for 2017. As noted in a July 16 letter opposing the decision, the risk
adjustment program protects insurers from unanticipated costs in the event their enrollees are
less healthy by transferring funds from plans with healthier enrollees. It is the only ACA
premium stabilization program that is permanent. The letter was signed by our AMA and 27
other organizations representing physicians, hospitals, and patients. Members of both parties in
Congress also expressed concern with the decision. Late on July 24, CMS announced that the
program would be reinstated following changes to the methodology that had played a part in
the decision to suspend the program.

• On July 10, CMS announced a significant cut to funding for consumer enrollment assistance
and outreach through the navigator program. Funding for the 34 states with ACA federal
market places was cut to $10 million, 80 percent less than just two years previous. Again, the
patient and provider community came together to protest this action. On July 26, 190
organizations, including the AMA, wrote HHS Secretary Alex Azar and CMS administrator
Seema Verma protesting the decision and urging the restoration of outreach funding.

• On August 1, the Administration gave the go ahead for short-term limited-duration plans of
364 days, with renewals allowed for up to 36 months. The plans would not be required to
comply with ACA protections such as coverage for pre-existing conditions or provide for
comprehensive benefits. In earlier comments urging withdrawal of the proposal, our AMA had
expressed support for the goal of increasing health plan choices but warned that the proposal
would undercut crucial state and federal patient protections, disrupt and destabilize the
individual market and result in substandard, inadequate health insurance coverage.

REPEAL AND APPROPRIATE REPLACEMENT OF THE SGR AND PAY-FOR-
PERFORMANCE

On July 12, CMS released a proposed rule for calendar year 2019 addressing both the Medicare
Physician Fee Schedule and the Quality Payment Program. In addition to the implementation of
Medicare Access and CHIP Reauthorization Act (MACRA) modifications enacted as part of the
Bipartisan Budget Act of 2018 (BBA18), discussed in a previous edition of this report, there are a
number of additional positive elements in the 2019 Proposed Rule. These include:

• Reduced documentation burden for Evaluation & Management (E&M) office visit codes,
though at this time, the degree of actual burden reduction is uncertain.

• New payments for physician services that are not part of a face-to-face visit (virtual check-ins
with patients, remote consults with patients using videos/photographs, online consults with
other physicians).

• Continuation of low volume threshold policy to exempt small practices from the Merit-based
Incentive Payment System (MIPS).

• A reduction in problematic measures in the Promoting Interoperability provisions (formerly
Meaningful Use and Advancing Care Information).

There are, however, areas of concern where the AMA will be recommending changes, including:

• E&M coding and related policies (add-on codes, multiple same day service reduction).

• AMA will urge reductions in quality measure requirements to reflect reductions in available
quality measures.

• Simplifying the MIPS scoring framework to make it more clinically relevant and
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
excludes some items and services from being considered as other coverage if provided at an employer-owned or retail clinic; allows transfer of funds from an FSA or HRA to an HSA under certain circumstances; and allows individuals to maintain eligibility for an HSA if their spouse had coverage under an FSA as long as the FSA is limited to expenses incurred by the spouse.

H.R. 6311, Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts Act of 2018, passed the House by a vote of 242-176. The bill would delay for another two years the Health Insurance Tax imposed by the ACA. It would also allow anyone to purchase a catastrophic plan, as opposed to the current limitation to those under age 30 or with specific hardship conditions. The bill increases allowed HSA contributions to match the maximum in allowed out-of-pocket costs and would allow bronze and catastrophic plans offered through ACA exchanges to be used with an HSA. H.R. 6311 also allows beneficiaries enrolled only in Medicare Part A to contribute to an HSA and allows FSA balances to be carried over to subsequent years, though any contribution limits for the next year would be lowered by the amount over $500 that was carried over.

At this writing, the potential for Senate consideration is not clear.

STEPS TO LOWER HEALTH CARE COSTS

Our AMA continues to engage with Congress and the Administration on a wide range of efforts designed to lower health care costs. Ongoing efforts to address the cost of prescription drugs remain among the highest profile of these efforts. On July 16, the AMA filed comments on the Administration’s “Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs.” In the comments, AMA noted that “patients are increasingly taking greater clinical risks when treatments are cost prohibitive.” AMA comments, which are available on the AMA website, addressed a wide range of cost drivers, including issues related to competition, transparency, the Part B drug benefit program, value-based pricing, and the 340B discount program.

During June and July, the Senate Committee on Health, Education, Labor and Pensions held a series of hearings on reducing health care costs focusing on rural health cost drivers, administrative costs, the role of quality and value in reducing excess spending. The AMA remains engaged in conversation with the committee as well as in other Congressional efforts to address the impact of administrative and regulatory costs and improve transparency of health care costs.

REPEAL NON-PHYSICIAN PROVIDER NON-DISCRIMINATION PROVISIONS OF THE ACA

Guidance released by the Department of Health and Human Services in 2014 included a positive interpretation of health plan requirements under section 2706(a) of the ACA, specifically clarifying that the section does not require “that a group health plan or health insurance issuer contract with any provider willing to abide by the terms and conditions for participation.” Nevertheless, the AMA will continue to seek legislative opportunities to repeal this provision.

CONCLUSION

Our AMA will remain engaged in efforts to improve the health care system through policies outlined in D-165.938 and other directives of the House of Delegates.
EXECUTIVE SUMMARY

Policy G-640.005, “AMA Advocacy Analysis,” calls on the Board of Trustees (BOT) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year’s advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The BOT has prepared 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 3-1-18

Subject: 2018 AMA Advocacy Efforts

Presented by: Jack Resneck, Jr., MD, Chair

BACKGROUND

Policy G-640.005, “AMA Advocacy Analysis,” calls on the Board of Trustees (BOT) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year’s advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The BOT has prepared the following report to provide an update on 2018 American Medical Association (AMA) advocacy activities.

Once again in 2018, the AMA was a strong and effective advocate for our nation’s patients and physicians. Key wins included Anthem’s reversal of its Modifier 25 policy, Quality Payment Program (QPP) improvements, repeal of the Independent Payment Advisory Board (IPAB), and extension of the Children’s Health Insurance Program for 10 years. The AMA also conducted impactful research such as the Economic Impact Study report. AMPAC continued its strong performance and positioned the AMA to be influential in the 2018 elections (see separate report in Not for Official Business Bag). Finally, AMA grassroots networks and microsites were extremely effective with over 2 million grassroots engagements to advance our advocacy agenda through social media.

DISCUSSION OF 2018 ADVOCACY EFFORTS

Health system reform

In the Bipartisan Budget Act of 2018, Congress repealed the Independent Payment Advisory Board (IPAB) which was an AMA priority and came after several years of strong Federation advocacy. In the same bill, Congress extended the Children’s Health Insurance Program (CHIP) for 10 years. Further, the AMA convinced Congress to strike the House-passed language that would have extended the expiring “misvalued codes” provision for an additional year in 2019. Such a provision would have had both short term and longer term negative effects for physicians.

On June 7, 2018, the Department of Justice filed a brief declining to defend the Affordable Care Act (ACA) in a case (Texas v. United States) brought by 20 state attorneys general. A week later, the AMA and four physician specialty associations filed an amicus brief urging the court to reject the effort to undermine the patient care gains under 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 life-time dollar limits could be reinstated, leading to more bankruptcies due to health

care costs.

Also in 2018, the Administration and the Congress attempted to continue chipping away at the
infrastructure of the ACA. The major “repeal and replace” efforts from 2017 were not repeated, but
there were several efforts to modify the ACA’s impact. The AMA commented extensively in the
regulatory process on the Administration’s actions—cutting back funds for navigators, shortening
the enrollment period, eliminating the cost sharing reduction subsidies, expanding association
health plans and short-duration limited coverage plans, and reducing risk adjustment payments.
The AMA is concerned that these actions will lead to higher cost/lower quality health plan choices
for many patients. The AMA is also opposing Medicaid work requirements that are being
considered by both federal and state policymakers.

QPP implementation

The AMA continues to support physicians as they transition to the Quality Payment Program
(QPP). The AMA is also working to improve the QPP at both the regulatory and legislative levels.
The Bipartisan Budget Act of 2018 included a number of QPP refinements requested by the AMA:

• Medicare Part B drug costs will be excluded from the Merit-based Incentive Payment System
  (MIPS) payment adjustments and from the low-volume threshold determination;
• The Centers for Medicare & Medicaid Services (CMS) may reweight the MIPS cost
  performance category to not less than 10 percent for the third, fourth and fifth program years
  (rather than requiring a weight of 30 percent in the third year);
• CMS has more flexibility in setting the MIPS performance threshold for years three through
  five to ensure a gradual and incremental transition to the threshold being set at the mean or
  median performance level in the sixth year; and
• The Physician Focused Payment Model Technical Advisory Committee may provide initial
  feedback regarding the extent to which alternative payment model proposals meet criteria and
  an explanation of the basis for the feedback.

On July 12, CMS released a proposed rule covering Medicare physician fee schedule and QPP
changes for 2019. Positive elements of the proposal included:

• Reduced documentation burden for evaluation and management (E/M) office visit services;
• New payments for services that are not part of a face-to-face visit (e.g., virtual check-ins with
  patients, remote patient consults using videos/photographs, online consults with other
  physicians);
• Continuation of the low volume threshold policy to exempt practices from MIPS; and
• A reduction in problematic measures in the Promoting Interoperability component of MIPS
  (formerly Meaningful Use and Advancing Care Information).

However, there were also several areas of concern for which the AMA will be recommending
changes in its comments to CMS, which are due on September 10. These include:

• A proposed collapse of E/M payments for physician office visit codes;
• Reduced payments for office visits and procedures performed on the same day; and
• The need for a simplified MIPS scoring framework and reduced quality measure requirements.

The AMA has been working with Federation groups to further identify positive and problematic
aspects of the proposed regulations, as well as potential constructive solutions.
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
released a set of 21 Prior Authorization and Utilization Management Reform Principles. Over 100
additional provider and patient groups have signed on to the principles as formal supporters. The
principles spurred conversations with health plans about the need for significant reform in PA
programs. One result of these discussions was the January 2018 release of the Consensus Statement
on Improving the Prior Authorization Process by the AMA, American Hospital Association,
America’s Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield
Association, and Medical Group Management Association. This document reflects an agreement
between provider and health plan organizations to pursue PA reform in several key areas.

State legislative efforts are also critical in the AMA’s campaign to improve PA processes, and the
AMA is working with state and specialty societies to enact PA and utilization management
legislation. The AMA offers model legislation that continues to serve as the basis for many of the
state bills and provides resources and support for these efforts. This year alone, more than 20 states
are addressing utilization management reform in their legislatures with significant enactments in
Indiana, New Mexico, and West Virginia. Physicians struggle with PA in the Medicare Advantage
(MA) and Medicare Part D drug plans, so the AMA is addressing PA issues at the federal level too.
These efforts include a recent AMA letter to CMS disputing the findings of a Government
Accountability Office report that recommended increased use of PA for Medicare-covered services.

The AMA has also launched a grassroots advocacy website dedicated to PA
(www.FixPriorAuth.org). The website includes both patient- and physician-oriented online
experiences that end with a “share your story” call to action. Compelling stories gathered thus far
are featured in the site’s story gallery, and additional physician and patient PA accounts will be
added over time and used to guide and support the AMA’s advocacy efforts. FixPriorAuth.org also
contains a resource library of PA-related news stories and AMA PA advocacy and educational
tools, including the three-part video series on electronic prior authorization that has been approved
for 0.25 credits of AMA PRA Category 1 Credit™.

**Telemedicine**

After concerted AMA advocacy coupled with the efforts of the Digital Medicine Payment
Advisory Group (DMPAG), beginning January 1, 2018, Medicare expanded coverage of remote
patient chronic care management. This represents a historic expansion of coverage that extends
throughout the country without geographic limitations and includes services delivered virtually in a
patient’s home. In addition, CMS has proposed to cover additional remote patient management
services including a range of technical and professional components that accurately reflect the costs
of delivering such services beginning January 1, 2019. Furthermore, the AMA’s coalition building
and strong support for the Medicare telehealth provisions of the Bipartisan Budget Act of 2018
which passed earlier this year paves the way for expanded Medicare coverage for telestroke and
telehealth services for patients with end stage renal disease, chronically ill patients in Medicare
Advantage, as well as coverage of telehealth for beneficiaries in certain accountable care
organizations (two-sided risk models only).

The AMA has also worked at the state level to ensure coverage of telemedicine and modernization
of medical practice acts. In the 2018 legislative session, 44 states introduced over 160 telehealth-
related pieces of legislation. Many bills addressed different aspects of payment regarding both
private payers and Medicaid, with some bills making changes to existing payment laws. Many
states also proposed legislation directing licensure boards to establish standards for the practice of
telehealth within their given profession. The AMA was pleased to see that many of these bills were
either based on the AMA Telemedicine Act, or were amended to incorporate language from this
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
also submitted extensive comments to the DOJ on the proposed merger on August 8. At the time of this report, the outcome of the proposed merger had yet to be decided, so AMA advocacy continues.

**Insurer coverage issues**

In 2018, the AMA continued to collaborate with state and specialty medical societies to ensure that patients have appropriate coverage for unanticipated out-of-network care. The AMA continues to promote coverage policies that are based on reasonable physician charges, to financially protect patients and promote fair contracting between physicians and insurers. AMA model legislation serves as the basis for many of these proactive efforts. Similarly, problematic state bills have been regularly defeated as the AMA and medical societies communicate to legislators about their impact on patient access to care and physician practice stability. The AMA has worked closely with state medical associations and the American College of Emergency Physicians (ACEP) to combat Anthem/BCBS policies that deny coverage for emergency care when the final diagnosis is determined to be non-emergent. Legislative restrictions were adopted in Missouri.

**Modifier 25**

At the 2017 Interim Meeting, the House of Delegates established new policy to advocate against payment reductions for evaluation and management (E/M) codes appropriately reported with a Current Procedural Terminology (CPT) modifier 25. Considerable concerns regarding this issue have been raised by many state medical associations and national medical specialty societies, most recently in regard to health insurer Anthem’s proposed policy to reduce payments by 50 percent for E/M services billed with CPT modifier 25 when reported with a minor surgical procedure code beginning in the first quarter of 2018. Several other insurers have followed suit with similar proposals.

Starting in November 2017, the AMA advocated directly to Anthem to halt this proposed move. The AMA sent a letter to Anthem expressing our concerns and hosted two meetings with AMA and Anthem senior leadership. During these discussions, the AMA voiced strong objections to this unwarranted reduction in physician payment and presented evidence showing that the recommendations of the AMA/Specialty Society Relative Value Scale Update Committee (RUC) do not include duplicative physician work or practice expense for procedures typically billed with an E/M service on the same date. Many state medical associations and national medical specialty societies also strongly advocated for Anthem to rescind this policy, which would impede the provision of unscheduled, medically necessary care. Following these combined efforts, Anthem withdrew its modifier 25 payment reduction. The AMA welcomed this news, as this policy would have had resulted in a $100 million cut in physician payments nationwide.

The AMA has continued advocacy on this issue, to include provision of supporting documentation to assist medical societies in successfully fighting implementation of modifier 25 payment reductions by Blue Cross Blue Shield of Michigan and Health Net in California. This will be an ongoing campaign, and the AMA will engage national commercial insurers and governmental entities considering similar policies involving modifier 25 or other CPT modifiers. The Centers for Medicaid & Medicaid Services proposed a new application of the Modifier 25 policy as part of the Evaluation and Management coding proposals. In comments on the proposed rule, the AMA stressed that these reductions were inappropriate and if advanced would necessitate an extensive 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](http://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
regulatory action to increase pharmaceutical market competition and combat anti-competitive practices; (3) ensuring prescribers have accurate point-of-care coverage and patient cost-sharing information as part of their workflow, including in the electronic health record (EHR); and (4) ensuring federal programs and commercial practices billed as lowering prescription medication prices do so for patients directly. The AMA identified and expressed concern about Blueprint proposals that would increase patient costs and erect barriers, including onerous insurer paperwork requirements that impede timely patient access to affordable and medically necessary medications and treatments. Further, the AMA opposes policies that would financially penalize physicians and pharmacists for high cost prescription medication.

The AMA also sent a letter of support to the Hill for S. 2554, which would prohibit the use of gag clauses in a manner the AMA strongly supports and would provide the Federal Trade Commission with clear authority to combat pay for delay agreements entered into between biological/biosimilar companies.

The AMA has also been working to influence legislative efforts at the state level to address drug costs, often by questioning the business practices and value equation that pharmacy benefit managers (PBMs) add to the system. The AMA has been engaged in the development of model bills by both the National Association of Insurance Commissioners (NAIC) and the National Conference of Insurance Legislators (NCOIL) to better regulate PBM practices. Additionally, nearly 20 states have now enacted legislation to allow pharmacists to discuss drug costs and payment options with patients (gag clause legislation)—policies supported by the AMA and outlined in AMA model legislation.

Gun violence

After another series of tragic mass shootings, the AMA renewed the call for the U.S. Centers for Disease Control and Prevention (CDC) to investigate the root causes of gun violence. There is concern that the CDC is prohibited from conducting this research, but the Dickey Amendment only prohibits the CDC from using appropriated funds “to advocate or promote gun control.” The AMA urged Congress to earmark appropriations specifically for gun violence research efforts. It also commented on proposed regulations issued by the Department of Justice on so-called “bump stocks.”

As the push for federal funding continues, the AMA recently partnered with the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM), a physician-led, non-profit organization that aims to counter the lack of federal funding for gun violence research by sponsoring gun violence research with privately-raised funds. AMA Trustee, Albert Osbahr, III, MD, is on AFFIRM’s steering committee; other physician group partners include the American College of Surgeons, American College of Emergency Physicians, and the Massachusetts Medical Society. More information about the group can be found at www.affirmresearch.org.

In 2018, nine states (Kansas, Louisiana, Maryland, New York, Ohio, Oregon, Utah, Vermont and Washington) enacted laws restricting access to firearms for individuals convicted of domestic violence or subject to a restraining order due to domestic violence. Delaware, Florida, Illinois, Maryland, Massachusetts, New Jersey, Rhode Island and Vermont passed laws establishing gun violence restraining orders. Nine states (Connecticut, Delaware, Florida, Hawaii, Maryland, New Jersey, Rhode Island, Vermont, and Washington) banned bump stocks. Finally, Florida, Louisiana, 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.
In addition, the AMA advocated before the U.S. Department of Veterans Affairs and the Department of Defense on coverage for transgender-related health care services.

**Tobacco**

The AMA along with more than a dozen other physician groups sent a letter to ranking members of the Senate and House appropriations committees urging them to oppose any provisions that weaken or delay the U.S. Food and Drug Administration’s (FDA) ability to regulate any and all tobacco products. Responding to provisions passed by the House in recent years that exempt thousands of tobacco products—including many candy- and fruit-flavored products now favored by teens—from the scientific review process mandated by the Family Smoking and Prevention Tobacco Control Act is cause for concern as 11.3 percent of high school students in 2016 reported using e-cigarettes during the last 30 days. Under these House provisions, many tobacco products that the FDA had only just begun to regulate, such as e-cigarettes and cigars, would be exempted from a product review if they were on the market prior to Aug. 8, 2016. The oft-cited reason for these provisions is the ability of e-cigarettes to help smokers quit traditional cigarettes; however, the efficacy of this is not yet proven by the research.

At the state level, Maine and Oregon raised the tobacco purchase age to 21. Five states now have this requirement. California, Hawaii, and New Jersey enacted laws in previous sessions.

**Economic Impact Study**

At the beginning of 2018, the AMA released its updated Economic Impact Study. The report gives policymakers concrete evidence demonstrating how their local communities tangibly benefit when they support legislation that helps physician practices thrive. The 2018 study found that nationally:

- Physicians support nearly 12.6 million jobs. On average, each physician supports more than 17 jobs;
- Physicians create a total of $2.3 trillion in economic output, comprising about 13 percent of the total U.S. economy. On average, each physician supports $3.2 million in economic output;
- Physicians contribute more than $1 trillion in wages and benefits for all supported jobs. On average, physicians support $1.4 million in total wages and benefits per physician; and
- Physicians support $92.9 billion in state and local tax revenues—approximately $126 thousand per physician on average.

**AMPAC Activities**

AMPAC has once again worked closely with its state medical association PAC partners this election cycle on contribution support decisions for candidates running Congress. A report summarizing AMPAC activities will be distributed at the Interim Meeting in National Harbor.

**CONCLUSION**

Once again, the AMA has delivered some significant advocacy victories in a challenging political environment. The outcome of the 2018 elections is unknown at the time this report was prepared, but the AMA is poised to work with both sides of the aisle in 2019 to advance the interests of patients and physicians on the most critical health care issues. The AMA thanks its Federation partners for their collaboration and support and looks forward to tackling medicine’s biggest issues when newly elected state and federal officials take office in January.
INTRODUCTION

At the 2017 Interim Meeting, the House of Delegates adopted Policy D-110.988[2] “Prescription Drug Price and Cost Transparency,” which asked for a report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign. This report, which is presented for the information of the House, summarizes the creation of the TruthinRx grassroots campaign, its evolution, and its progress and impact. The report also summarizes relevant American Medical Association (AMA) policy and advocacy, which is reflected in the TruthinRx grassroots campaign.

BACKGROUND

In 2015, Policy H-110.987, “Pharmaceutical Costs,” directed the AMA to convene a task force of appropriate AMA Councils, state medical societies, and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. Accordingly, the AMA convened a Task Force on Pharmaceutical Costs, which met four times in the first six months of 2016 to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs. The Task Force agreed that increasing transparency among pharmaceutical companies, health plans, and pharmacy benefit managers (PBMs) should be the initial focus of the campaign, which led to the launch of a grassroots campaign in the third quarter of 2016, and the launch of the TruthinRx website, TruthinRx.org, on November 1, 2016.

EVOLUTION OF THE TRUTHINRX GRASSROOTS CAMPAIGN

The goal of the TruthinRx campaign has been to mobilize the AMA Physician Grassroots Network (PGN), the AMA Patient Action Network (PAN), the public, and thought leaders around the challenges posed by the lack of transparency surrounding prescription drug pricing and costs. TruthinRx.org engages physicians, patients/consumers, and health care policy influencers by:

(a) providing critical information about prescription drug price and cost challenges, as well as the lack of drug price and cost transparency, and (b) facilitating grassroots action in support of improving prescription drug price and cost transparency. Since its launch in November 2016, TruthinRx.org has evolved through two key stages. In its first stage, the TruthinRx.org landing page focused on informing visitors about how drug price negotiations happen behind closed doors and how pharmaceutical companies, PBMs, and health insurance companies participate in these negotiations. The page concludes that “when patients are left out, health care suffers.” This landing page directs visitors to four main website subsections:

• “Your Stories” – invites visitors to read and contribute their own stories about how the lack of transparency in drug pricing impacts our health care system.
“Behind the Label” – illustrates how the lack of transparency in prescription drug pricing and costs – involving opaque price agreements between PBMs, health plans, and pharmaceutical manufacturers – contributes to adverse patient effects such as increased costs and unpredictable price swings for patients, and ultimately adversely affects patients and physicians.

“Get Involved” – facilitates grassroots advocacy by providing visitors with a customizable message that can be personalized to US Senators and Representatives, calling on legislators to support increased transparency in prescription drug prices. Additionally, visitors have an opportunity to subscribe to future legislative updates and alerts from the AMA.

“Get Informed” – provides visitors with a myriad of timely articles to help them understand the seemingly arbitrary costs of prescription medication. The articles are categorized according to the following thought-provoking questions:

- “What influences the price of drugs?”
- “How does drug pricing affect patients like you?”
- “What’s being done to help?”

At the time that this report was written, the second stage of TruthinRx.org was scheduled to be launched in fall of 2018 to further mobilize voters around the issue of prescription drug price transparency. TruthinRx.org will include an interactive data visualization that highlights various reasons why drug prices fluctuate. The data visualization will explore the roles of four key themes behind drug price fluctuation: (1) generics – despite the assumption that generic drugs will be affordable, over time, the prices of generic drugs can rise significantly; (2) competition – despite the expectation that competition in the marketplace would lead to lower prices, competitors’ prices can seemingly increase simultaneously; (3) acquisition – the price of drugs produced by a given company can rise significantly after the company is acquired; and (4) supply chain dynamics – PBMs cast themselves as saving money, but with the lack of supply chain transparency, it is unclear how these middlemen negotiate drug prices. The data visualization will lead to a call to action for improved transparency. This interactive subsection of TruthinRx.org can be used both on mobile and desktop devices, and is designed so that it can be shared on social media.

PROGRESS AND IMPACT OF THE TRUTHINRX GRASSROOTS CAMPAIGN

The TruthinRx grassroots campaign has significantly impacted public awareness of, and grassroots action in response to, the opaque process that pharmaceutical companies, PBMs, and health plans engage in when pricing prescription drugs. Between the website’s launch in November 2016 and August 2018, the TruthinRx campaign has achieved the following milestones:

- The TruthinRx campaign generated 827,759 messages sent to Congress demanding price transparency.
- As part of the TruthinRx grassroots campaign, the PAN launched a petition calling for increased prescription drug price and cost transparency, and this petition has been signed by 275,590 individuals.
- TruthinRx.org has been visited 117,474 times, by 95,873 unique internet users.
- The AMA has published 656 posts on Twitter and Facebook focused on the TruthinRx campaign. Combined, these posts were displayed 10,859,853 times (“impressions”). This led to 514,118 people interacting with the posts (“engagements”).
- Evidencing the TruthinRx campaign’s continued impact on public discussion, since July 2017, the hashtag “#TruthinRx” has been mentioned on Twitter and/or Facebook 1,617 times.
AMA POLICY AND ACTIVITY

It is important to recognize that the TruthinRx grassroots campaign is one key component of a much broader, ongoing AMA focus on prescription drug affordability. Recent AMA policy and activity aimed at improving prescription drug price and cost transparency include:

- The AMA developed and disseminated model state legislation entitled, “An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases during the Plan Year.”
- The AMA submitted comments in July 2018 in response to the HHS Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs. Patient and other stakeholder experiences with affordability and lack of access that were obtained through the TruthinRx campaign were incorporated as vignettes in this comment letter. The AMA has received positive feedback on these vignettes.
- In April 2018, Jack Resneck, Jr., MD, testified at the US House of Representatives Democratic Steering and Policy Committee Briefing on Prescription Medication Pricing and Access Challenges and Solutions. Dr. Resneck’s testimony focused on how the lack of prescription drug pricing transparency impacts his patients.
- In December 2017, Gerald e. Harmon, MD, testified before the Health Subcommittee of the US House of Representatives Committee on Energy and Commerce on the topic of “Examining the Pharmaceutical Supply Chain.” Dr. Harmon’s testimony focused on what the escalating cost and complexity of obtaining medically necessary prescriptions or physician-administered drug treatments mean for patient adherence, timely access, and health outcomes.
- Policy H-110.987, which encourages prescription drug price and cost transparency among pharmaceutical companies, PBMs, and health insurance companies and establishes extensive AMA policy aimed at improving access to affordable prescription drugs, including: promoting legislation that authorizes the Attorney General and/or the Federal Trade Commission (FTC) to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients, and encouraging FTC actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers.
- Policy H-110.987, also directs the AMA to provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
- Policy H-110.991, which advocates for greater prescription drug price transparency at the pharmacy point-of-sale.
- Policy H-110.991, also supports physician education regarding drug price and cost transparency and challenges patients may encounter at the pharmacy point-of-sale.

Moreover, the AMA is continuing to develop evolving policy in support of improved prescription drug affordability. Ongoing AMA initiatives include:

- At this Interim Meeting, the Council on Medical Service is presenting Report 1-I-18 that addresses prescription drug importation for personal use.
- At the 2019 Annual Meeting, the Council on Medical Service will present a report that addresses the impact of PBMs on patients.
- At the 2019 Annual Meeting, the Board of Trustees will present a report that addresses three related referred resolutions that address reforming the Orphan Drug Act, legislation related to an optional national prescription drug formulary, and modifications to the Hatch-Waxman Act and Biologics Price Competition and Innovation Act (i.e., Biosimilars Act).
CONCLUSION

In the approximately two years since the TruthinRx grassroots campaign was launched, the initiative has demonstrated significant success in engaging physicians, patients/consumers, and health care policy influencers in discussion of and advocacy to improve prescription drug price and cost transparency. As described above, the TruthinRx campaign is a key component of a broader, ongoing AMA focus on prescription drug affordability, and TruthinRx.org will continue to evolve as relevant AMA policy evolves. The objective metrics outlined above indicate that the TruthinRx grassroots campaign is succeeding in stimulating public discourse, and TruthinRx.org will continue to be updated to capture public attention and mobilize action.
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,
distribution, and awareness elements conducive to wide spread scaling. In this regard, we continue to define and promote the “business case” for public and private payer coverage of proven interventions such as diabetes prevention programs (for which Medicare began coverage in 2018) and self-measured blood pressure monitoring devices. Looking forward in 2019, we intend to blend the “best of” our prediabetes and hypertension work and add programming on cholesterol management to assist physicians and care teams more comprehensively with cardiovascular risk reduction for their patients.

REIMAGINE MEDICAL EDUCATION, TRAINING, AND LIFE LONG LEARNING

We are committed to a comprehensive approach to physician professional education and learning. In 2019, the AMA will have mature and substantial effort in undergraduate medical education, be expanding to graduate medical education and have a growing presence in physician lifelong learning. These programs are designed to respond to the on the ground needs of physicians in the evolving environment in which practice by utilizing modern adult education knowledge and digital technology.

Since 2013 the AMA has supported a Consortium of medical schools, now 32 in number, to accelerate change in medical education by creating a system that trains physicians to meet the needs of today's patients and to anticipate future changes. Facilitated by the AMA through individual and collaborative work the consortium schools have created new and innovative programs and technologies that are increasingly adopted by medical schools throughout the nation. Of particular note are the consortium’s health system science textbook that is being adopted by more and more medical schools and the successful application of the chronic care curriculum based on work done in our Improving Health Outcomes area. The latter is an example of the application of work emanating from one strategic area to another critical arena.

The initial grant period of the Consortium ends in 2018, but due to the success of this collaboration the schools have committed to continue to work together with AMA programmatic support to sustain and grow this community of innovation, but without further grant funds. This is an example of our efforts to cost effectively catalyze change through partnerships and collaborations. In 2019, based on the experience and learning from the work in undergraduate medical education, we will initiate a multi-year program to smooth the transition from medical school to residency through a number of demonstration programs that include medical schools, residency programs, and associated health systems.

In 2018, we continued to build education delivery capabilities with the development and launch of the new AMA Ed Hub™ platform. The platform blends innovations in content, technology, and user experience to deliver increasingly more personalized and compelling virtual learning experiences to meet individual needs and preferences. AMA Ed Hub brings together the AMA’s diverse educational offerings under one unified umbrella. Included are Learning™, STEPS Forward™, GME Competency Education Program (GCEP), e-learning modules that support the AMA’s Health Systems Science textbook, interactive micro-learning modules based on the AMA’s modernized Code of Medical Ethics, curricula related to pain management, firearm safety and other topics. As we look to 2019 and beyond, we will continue to build and enhance the platform as a set of digital solutions that optimizes discovery of educational content for individual users, facilitates delivery of an educational curriculum at an organization level, explores innovations in learning experiences more closely connected to physicians’ daily practice, and expands automatic reporting capabilities to support licensure and certification. We also will be exploring collaborations with other organizations to advance both educational content and platform offerings.
ENGAGING PHYSICIANS AND ADVANCING THE MISSION

Our ambitions are high and we must utilize all available tools and assets to reach them. To this end we wish to highlight three areas of leverage.

First, beginning in 2016 we have been building an innovation ecosystem that connects AMA experience, knowledge, and mission priorities with technology and private sector groups. Our wholly owned Silicon Valley situated subsidiary Health 2047 is a centerpiece of this effort. Accessing world class technology, product development, and venture expertise it focuses on the commercial complements of the AMA’s strategic arcs. It has already founded a data interoperability company and we anticipate several new ventures in 2019 that will address other important areas that advance our mission.

Second, the goal of health equity is infused in all our strategic work. Each of the mission areas have components directed toward the health equity goal. Based on guidance from the House and with the support of the Board of Trustees in 2019 AMA management will establish a functional hub that further facilitates and enhances concentration on this area. The unit’s objective will be to ensure optimal coordination, collaboration, and program development across the AMA’s mission areas in support of our commitment to national health equity.

Third, as evidence of AMA mission impact continues to grow, there is an opportunity for AMA to deepen its engagement and strengthen its brand identity among physicians, students, residents and other stakeholders. By leveraging more sophisticated approaches to identifying interests and needs of the physician population, we can continuously improve our services and offerings to retain and grow our membership base. We will create new connections, drive awareness and increase opportunities to interact with the AMA using traditional and interactive/social/digital media, building off our experience in 2018.

The momentum that supports this multi-year strategy is a reflection of collaboration and shared commitment across the AMA and the Federation of medicine, academic institutions, public and private health sector organizations, technology innovators, physicians, and physicians in training. Together we will chart a course for health care delivery that will improve the health of the nation.
Subject: Medical Tourism

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 3-A-18, “Medical Tourism.” 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-1.2.13 – Medical Tourism

Medical tourists travel to address what they deem to be unmet personal medical needs, prompted by issues of cost, timely access to services, higher quality of care or perceived superior services, or to access services that are not available in their country of residence. In many instances, patients travel on their own initiative, with or without consulting their physician, and with or without utilizing the services of commercial medical tourism companies. The care medical tourists seek may be elective procedures, medically necessary standard care, or care that is unapproved or legally or ethically prohibited in their home system.

Many medical tourists receive excellent care, but issues of safety and quality can loom large. Substandard surgical care, poor infection control, inadequate screening of blood products, and falsified or outdated medications in lower income settings of care can pose greater risks than patients would face at home. Medical tourists also face heightened travel-related risks. Patients who develop complications may need extensive follow-up care when they return home. They may pose public health risks to their home communities as well.

Medical tourism can leave home country physicians in problematic positions: Faced with the reality that medical tourists often need follow-up when they return, even if only to monitor the course of an uneventful recovery; confronted with the fact that returning medical tourists often do not have records of the procedures they underwent and the medications they received, or contact information for the foreign health care professionals who provided services, asked to make right what went wrong when patients experience complications as a result of medical travel, often having not been informed about, let alone part of the patient’s decision to seek 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)
Subject: Expanded Access to Investigational Therapies

Presented by: James E. Sabin, MD, Chair

INTRODUCTION


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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(b) As part of the informed consent process, advise the patient (or parent/guardian if the patient is a minor) that the investigational therapy has not yet been demonstrated to be effective in treating the patient’s condition and may pose as yet unknown risks. Physicians should explain the importance of clinical trials, encourage patients who meet inclusion criteria to participate in an existing trial rather than seek access to investigational therapy through the FDA expanded access program, and direct patients who wish to participate in research to appropriate resources.

(c) Decline to support an application for expanded access to an investigational therapy when:

(i) the physician judges the treatment with the investigational therapy not to be in the patient’s best interest, and explain why; or

(ii) the physician does not have appropriate resources and ability to safely supervise the patient’s care under expanded access.

In such cases, physicians should refer the patient to another physician with whom to discuss possible application for expanded access.

(d) Discuss the implications of expanded access for the patient and family and help them form realistic expectations about what it will mean to be treated with the investigational therapy outside a clinical trial. Physicians should alert patients:

(i) to the possibility of financial or other responsibilities associated with receiving an investigational therapy through expanded access;

(ii) to the lack of infrastructure to systematically monitor and evaluate the effects of the investigational therapy outside a clinical trial;

(iii) that they need information about how to contact the manufacturer for guidance if they seek emergency care from a health care professional who is not affiliated with a clinical trial of the investigational therapy;

(iv) that the physician has a responsibility to collect and share clinical information about the patient’s course of treatment with the investigational therapy, as well as to report any adverse events that may occur over the course of treatment;

(v) to the conditions under which the physician would recommend stopping treatment 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

INTRODUCTION


E-1.2.13 – Mergers of Secular and Religiously Affiliated Health Care Institutions

The merger of secular health care institutions and those affiliated with a faith tradition can benefit patients and communities by sustaining the ability to provide a continuum of care locally in the face of financial and other pressures. Yet consolidation among health care institutions with diverging value commitments and missions may also result in limiting what services are available. Consolidation can be a source of tension for the physicians and other health care professionals who are employed by or affiliated with the consolidated health care entity.

Protecting the community that the institution serves as well as the integrity of the institution, the physicians and other professionals who practice in association with it, is an essential, but challenging responsibility.

Physician-leaders within institutions that have or are contemplating a merger of secular and faith-based institutions should:

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

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

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(c) Negotiate contractual issues of governance, management, financing, and personnel that will respect the diversity of values within the community and at minimum that the same breadth of services and care remain available to the community.

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

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

Individual physicians associated with secular and faith-based institutions that have or propose to consolidate should:

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

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

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.

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.

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
communication of groundbreaking ideas and projects. The AMA awarded grants to an additional
21 schools in 2016. Today, almost one-fifth of all U.S. allopathic and osteopathic medical schools
are represented in the 32-member consortium, which is delivering revolutionary educational
experiences to approximately 19,000 medical students—students who one day will provide care to
a potential 33 million patients annually.

A summary of innovations resulting from the Consortium can be found in Appendix B.
Additionally, a comprehensive, annotated bibliography of publications based on the work of the
Consortium has been published and is available for review.4

Innovative Educational Formats in the JAMA Network

The JN Listen™ app provides learners with convenient access to engaging podcasts based on peer-reviewed articles published in JAMA. Learners can listen to content they select and earn CME, all via the mobile app.

STEPS Forward™
The AMA STEPS Forward™ practice transformation series is an online educational product
designed to offer innovative strategies that assist physicians in the new health care environment.
Leveraging findings from an AMA-RAND study,5 the online modules provide clinicians and
practice managers with the data, tools, education, and certification needed to be successful in a
value-based payment environment. Learners can take courses about patient care, workflow and
process, and professional well-being, among other topics. All STEPS Forward™ modules are
Centers for Medicare & Medicaid Services-approved Clinical Practice Improvement Activities; by
completing these modules, physicians can demonstrate compliance with Merit-Based Incentive
Payment System requirements.

Recently, each of the 48 available modules’ learning objectives and assessments were revised to
ensure that learner expectations and outcomes are aligned. Content is currently being converted to a
standardized format for multichannel publication.

GME Competency Education Program

The AMA GME Competency Education Program (GCEP) comprises a series of online educational
modules designed to complement teaching in patient settings and didactic curricula in residency
and fellowship programs. The program helps residents and their institutions meet core competency
requirements. In 2018, GCEP was selected as a Gold winner in the 2018 Digital Health Awards,
which recognizes high-quality digital health resources for health professionals.

Over the past year, the 33-module GCEP library has been upgraded to add animation, case
vignettes, and mock simulations to help residents visualize how the content is applicable to their
daily practice. The final eight modules are currently being enhanced, including content on quality
improvement practices, promoting medication adherence, navigating a lawsuit, and creating an
effective and respectful learning environment, among other topics. Personalized instruction has
been incorporated, as well as guided learning using relatable mentor characters.

Health Systems Science

In addition to basic and clinical sciences, recognition is growing that physicians also need to know
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, 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, 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™ 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™ to attendees. The International Conference Recognition Program continues to this day, and international opportunities to earn AMA PRA Category 1 Credit™ 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.
Section/Council Educational Sessions

Since 2014, AMA sections and/or councils have produced approximately 120 educational sessions at the Annual and Interim meetings (15 sessions per meeting, on average), in addition to various other activities provided throughout the years. Nationally renowned experts, including many AMA members, have educated on important and timely topics, such as physician burnout, the opioid epidemic, firearm safety, value-based care, physician leadership, and innovation.

Collaboration with External Organizations

Our AMA continues to work to lessen the administrative burden for physicians by simplifying and streamlining the automatic tracking and reporting of credit to support certification and licensure needs. Currently, our AMA partners with the ACCME and ABIM to report completed JAMA Network CME activities on behalf of physicians certified by the ABIM. The AMA will extend these reporting capabilities to include all AMA educational activities and additional ABMS member boards in 2019. Finally, a pilot is being planned with the ACCME and Board of Medical Examiners in Tennessee to report completed activities on behalf of physicians licensed in Tennessee.

Our AMA has also been approved as an ABMS Multi-Specialty Portfolio Program sponsor and has developed CME programs that are eligible for continuing certification (MOC Part IV) credit.

Future Innovations

Additional planned innovations will focus on educational features and apps that offer innovation in the education space. Currently, our AMA is:

- Leveraging augmented intelligence to power learning experiences;
- Taking new approaches to documenting meaningful involvement in performance improvement; and
- Considering different types of assessment, which could expand the content for which credit can be offered.

Finally, our AMA is also exploring the potential of the AMA Ed Hub™ platform to be of service to other educational providers.

SUMMARY

For 150 years, our AMA has demonstrated a commitment to developing and supporting advancements in medical education, both autonomously and in partnership with others. From the Council on Medical Education’s contributions to the Flexner Report, to the groundbreaking Accelerating Change in Medical Education Consortium, to newly enhanced e-learning content design and delivery, our AMA is well positioned to lead medical education innovations into the 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.


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.


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 EDUCATION

<table>
<thead>
<tr>
<th>INNOVATION FOCUS</th>
<th>SUMMARY</th>
<th>PUBLICATIONS AND OUTCOMES</th>
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<tbody>
<tr>
<td>Developing flexible, competency-based pathways</td>
<td>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. These flexible, competency-based pathways create physicians who are comfortable assessing their abilities and addressing any deficiencies throughout their careers.</td>
<td>Generalizing Competency Assessment Scores Across and Within Clerkships&lt;sup&gt;9&lt;/sup&gt;</td>
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<td>Finding a Path to Entrustment in Undergraduate Medical Education&lt;sup&gt;10&lt;/sup&gt;</td>
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<td>Constructing a Shared Mental Model for Faculty Development in CEPAER&lt;sup&gt;11&lt;/sup&gt;</td>
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| Teaching new content in Health Systems Science       | 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.  
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. | *Health Systems Science*<sup>12</sup>                                                      |
<p>|                                                      |                                                                                                                                                                                                        | Investigate the Barriers to Integrating Health Systems Science in Medical Education&lt;sup&gt;13&lt;/sup&gt; |
|                                                      |                                                                                                                                                                                                        | Science of Health Care Delivery Milestones for Undergraduate Medical Education&lt;sup&gt;14&lt;/sup&gt; |
| Working with health care delivery systems in novel ways | Consortium schools are creating new learning experiences embedded within health care systems. 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 | 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&lt;sup&gt;15&lt;/sup&gt; |
|                                                      |                                                                                                                                                                                                        | Socially Accountable Medical Education: An Innovative Approach at Florida International University |
| Making technology work for learning | 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. 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. |
| Envisioning the master adaptive learner | 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. 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. |
| Shaping tomorrow’s leaders | 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>
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<th>Universal outcomes</th>
<th>Coaching Handbook&lt;sup&gt;25&lt;/sup&gt;</th>
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<tr>
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<td>Curricular Transformation: The Case Against Global Change&lt;sup&gt;26&lt;/sup&gt;</td>
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<td>Why Not Wait? Eight Institutions Share Their Experiences Moving United States Medical Licensing</td>
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<td>Examination Step 1 After Core Clinical Clerkships&lt;sup&gt;27&lt;/sup&gt;</td>
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<td>Turn Med Ed on its Head: Medical Education Innovation Challenge&lt;sup&gt;28&lt;/sup&gt;</td>
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<td>Creating an online community</td>
<td>Implementing a Teaching EHR as a Clinical Learning Platform&lt;sup&gt;29&lt;/sup&gt;</td>
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<td>Participants in this online community are discussing developments and innovations</td>
<td>Transforming Education: Leading Innovations in Health Professions Education&lt;sup&gt;30&lt;/sup&gt;</td>
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<td>in medical education, including the work emerging from the AMA’s Accelerating</td>
<td>Using Big Data to Teach Population Health&lt;sup&gt;31&lt;/sup&gt;</td>
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<td>Change in Medical Education Consortium, as part of the AMA’s work to create the</td>
<td>Health Systems Science: The Third Pillar of Medical Education&lt;sup&gt;32&lt;/sup&gt;</td>
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<td>medical schools of the future. Webinars educate and connect participants and</td>
<td>Interprofessional Education: Using Technology to Teach Team-Based Care&lt;sup&gt;33&lt;/sup&gt;</td>
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<td>help spread innovations nationally.</td>
<td>To Medical Student Wellness and Beyond: Creating a Healthy Culture for All&lt;sup&gt;34&lt;/sup&gt;</td>
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<td>Leadership Training: Developing the Next Generation of Physician Leaders</td>
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<td>Portfolios and Dashboards: Leveraging Data for Student Success</td>
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REFERENCES

18 [https://clinicallearning.how/](https://clinicallearning.how/).


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.
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 AMA Council on Medical Education has
approved new educational formats for AMA PRA Category 1 Credit™ 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.

Previous domestic credit system innovations include the following:

1. Permitting physicians to self-claim AMA PRA Category 2 Credit™ for educational
   experiences (not designated for AMA PRA Category 1 Credit™) that comply with the
   AMA definition of CME and pertinent Council on Ethical and Judicial Affairs opinions;
   and

2. Allowing physicians to apply directly to the AMA for AMA PRA Category 1 Credit™ for
defined activities that have been recognized as worthwhile learning experiences but are not
certified for credit through an accredited CME provider. These include teaching at live
CME activities that are designated for AMA PRA Category 1 Credit™; publishing articles
in MEDLINE indexed journals; presenting a poster that is included in the published
abstracts for a conference certified for AMA PRA Category 1 Credit™; earning medically-
related advanced degrees; completing an American Board of Medical Specialties (ABMS)
member board certification process (a primary ABMS member board
certification/recertification or a subspecialty board certification/ recertification); or
successfully completing an Accreditation Council for Graduate Medical Education-
accredited residency or fellowship.

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™ to attendees. The International Conference Recognition
Program continues to this day, and international opportunities to earn AMA PRA Category 1
Credit™ have expanded to include activities covered by agreements between the AMA and 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.

Finally, the AMA has embarked upon an ongoing process with the Accreditation Council for
Continuing Medical Education (ACCME) with the intent of aligning the credit and accreditation
systems and simplifying the process for both physicians and CME providers. Organizations that are
accredited by either the ACCME or an ACCME-recognized state medical society are given the
privilege, by the AMA, of certifying activities for AMA PRA Category 1 Credit™ and awarding
that credit to physicians. That privilege may be withdrawn by the AMA if the accredited CME
provider fails to bring the program and activities into compliance with AMA PRA policies,
regardless of accreditation status. Recently, the AMA developed a process with the ACCME to
revise requirements for accredited CME providers. That process led to development of aligned and
simplified requirements that became effective September 29, 2017. The AMA and the ACCME
will continue to work together to modernize and evolve CME activities while maintaining
educational quality.
CURRENT AMA POLICY

AMA policies related to this topic are listed in the Appendix.

SUMMARY

The past 50 years have seen many changes in CME, and the AMA has led many of these changes by adapting the AMA PRA and the credit system to include new concepts, introduce new ideas, and recognize the multiple ways in which physicians learn and improve. The AMA PRA credit system must continue to be responsive to the needs of physicians to ensure they are adequately recognized for their participation in certified CME activities. To achieve this goal, the Council on Medical Education recognizes the importance of its continued stewardship of this valuable process.

As the AMA celebrates the 50th anniversary of this award, the Council on Medical Education would like to draw attention to Policy H-300.959, “Physician Participation in the AMA Physician’s Recognition Award,” which states 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.” (CME Rep. 1, I-93; Reaffirmed with change in title: CME Rep. 2, A-05; 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™* 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 8-1-18

Subject: Study of Medical Student, Resident, and Physician Suicide

Presented by: Carol Berkowitz, MD, Chair

American Medical Association (AMA) Policy D-345.984, “Study of Medical Student, Resident, and Physician Suicide,” states:

That our American Medical Association 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.

This policy resulted from Resolution 019-A-18, which called for our AMA to conduct a study to accurately quantify the actual incidence of medical student, resident, and physician suicide. Testimony on this item was unanimously supportive during the hearing of the Reference Committee on Amendments to Constitution and Bylaws at the 2018 AMA Annual Meeting. In its report, the reference committee noted the severity of the issue of physician suicide and the significant need for attention to this problem. However, our AMA does not generally conduct independent empirical research. Therefore, the Reference Committee suggested amending Resolution 19-A-18 so that the AMA could determine the most efficient and accurate mechanism to accurately quantify the actual incidence of medical student, resident, and physician suicide. Your Reference Committee consequently recommended adoption with this amendment and a directive to report back findings at the 2018 Interim Meeting of the House of Delegates (HOD).

The AMA Council on Medical Education recognizes the salience and timeliness of this topic and agrees that appropriate resources should be dedicated to identify these mechanisms for study. However, meaningful and constructive review of this issue, and of the work done to date by other organizations, will require additional time. The Council therefore will present a report on this issue at the 2019 Annual Meeting of the HOD.
Subject: Recommendations for Policy Reconciliation

Presented by: Susan R. Bailey, MD, and Bruce A. Scott, MD

Policy G-600.111, “Consolidation and Reconciliation of AMA Policy,” calls on your Speakers to “present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete.”

Your Speakers present this report to deal with policies, or portions of policies, that are no longer relevant or that were affected by actions taken at the recent Annual Meeting. Suggestions on other policy statements that your Speakers might address should be sent to hod@ama-assn.org for possible action. Where changes to language will be made, additions are shown with underscore and deletions are shown with strikethrough.

RECOMMENDED RECONCILIATIONS

Obsolete references to be deleted from policies

Policy G-600.031 characterizes the roles and responsibilities of delegates and alternate delegates. The policy dates from 1999 and was most recently reaffirmed at the 2012 Annual Meeting. Your Speakers regard it as an important policy, but it includes a reference to a program that no longer exists. That clause will be deleted and a minor editorial change made.

G-600.031 Roles and Responsibilities of AMA Delegates and Alternate Delegates

(1) 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 email addresses so that the AMA can make the information accessible to individual members through the AMA Web site and through other communication mechanisms.

(2) The roles and responsibilities of delegates and alternate delegates are as follows: (a) regularly communicate AMA policy, information, activities, and programs to constituents so he/she will be recognized as the representative of the AMA; (b) relate constituent views and
suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff; (c) advocate constituent views within the House of Delegates or other governance unit, including the executive staff; (d) attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings; (e) serve as an advocate for patients to improve the health of the public and the health care system; (f) cultivate promising leaders for all levels of organized medicine and help them gain leadership positions; and (g) actively recruit new AMA members and help retain current members; and (h) participate in the AMA Membership Outreach Program.

Directives to be rescinded in full

The following directives will be rescinded in full, as the requested studies have been completed and presented to the House of Delegates.

At the 2017 Annual Meeting, the House adopted Policy D-215.987, “Studying Healthcare Institutions that Provide Child Care Services,” directing our AMA to work with relevant entities to study healthcare institutions to determine whether they provide childcare services and report on those findings at the 2018 Annual Meeting. Board of Trustees Report 32-A-18, “Studying Healthcare Institutions that Provide Child Care Services,” was presented to the House as an informational report and was filed. Consequently, the policy will be rescinded.

D-215.987, “Studying Healthcare Institutions that Provide Child Care Services”

1. Our AMA will work with relevant entities to study healthcare institutions to determine whether they provide childcare services. Survey elements should include the size of the institutions in terms of the number of physicians, physicians-in-training, and medical students, how these services are organized, and the various funding mechanisms.

2. Our AMA will report back to the House of Delegates at the 2018 Annual Meeting the results of its study on models used to provide childcare services, how these services are organized, and the various funding mechanisms. This report, which is presented for the information of the House, provides background on child care services in health care and the implications of access to child care for physicians, as well as results of a study conducted by the AMA and other relevant research.

Policy D-315.976, “Ownership of Patient Data,” calling for a study on the use of patient information by hospitals, was adopted at the 2017 Annual Meeting. The requested study was fulfilled by Board of Trustees Report 21-A-18, “Ownership of Patient Data,” an informational report that noted our AMA’s active engagement with the Department of Health and Human Services, the Office of the Inspector General and the Office of the National Coordinator based on policies covering all aspects of patient record maintenance, access and control. The policy will be rescinded.

D-315.976, “Ownership of Patient Data”

Our AMA will undertake a study of the use and misuse of patient information by hospitals, corporations, insurance companies, or big pharma, including the impact on patient safety, quality of care, and access to care when a patient’s data is withheld from his or her physician, with report back at the 2018 Annual Meeting.

Also adopted at the 2017 Annual Meeting was Policy D-405.982, “Management of Physician and Medical Student Stress,” which requested a report on various regulatory burdens placed on physicians. Your Board of Trustees presented an informational report, BOT Report 36-A-18,
“Management of Physician and Medical Student Stress” that fulfilled the request. Therefore the directive will be rescinded.

D-405.982, “Management of Physician and Medical Student Stress
Our AMA will produce a report on administrative and regulatory burdens placed on physicians, residents and fellows, and medical students, and pursue strategies to reduce these burdens.

CHANGES IN TERMINOLOGY

The following policy statements were updated to comport with AMA style and usage in references to continuing medical education credit for the AMA Physician’s Recognition Award. PolicyFinder now employs an italic typeface and the trademark (™) symbol in references to AMA PRA Category 1 Credit™ or AMA PRA Category 2 Credit™. The prior version of PolicyFinder did not allow these features. We point this out primarily to alert members of the House to the correct usage. It also happens that this year is the 50th Anniversary of the AMA Physician’s Recognition Award and Credit System.

The affected policies are:

- H-275.924, “Maintenance of Certification”
- H-295.926, “Support for Development of Continuing Education Programs for Primary Care Physicians in Non-Academic Settings”
- H-300.955, “Restructuring of Continuing Medical Education Credits”
- H-300.974, “Unification of Continuing Education Credits”
- H-300.977, “Revisions to the Physician's Recognition Award”

The changes outlined above do not reset the sunset clock and will be implemented when this report is filed.
Not for consideration

Resolutions not for consideration

601  Creation of an AMA Election Reform Committee
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
Whereas, Members of our AMA House of Delegates cherish our democratic process; and

Whereas, Our current election and voting process for AMA officers and council positions consumes a lot of time and financial resources; and

Whereas, Election reform would allow for more time for policy and debate during HOD sessions; and

Whereas, Cost barriers are often an impediment to candidate elections; and

Whereas, There are significant technological advances that could allow for an expedited process of elections and debate; therefore be it

RESOLVED, That our American Medical Association appoint a House of Delegates Election Reform Committee to examine ways to expedite and streamline the current election and voting process for AMA officers and council positions (Directive to Take Action); and be it further

RESOLVED, That such HOD Election Reform Committee consider, at a minimum, the following options:

- The creation of an interactive election web page;
- Candidate video submissions submitted in advance for HOD members to view;
- Eliminate all speeches and concession speeches during HOD deliberations, with the exception of the President-Elect, Speaker and Board of Trustee positions;
- Move elections earlier to the Sunday or Monday of the meeting;
- Conduct voting from HOD seats (Directive to Take Action); and be it further

RESOLVED, That our AMA review the methods to reduce and control the cost of campaigns (Directive to Take Action); and be it further

RESOLVED, That the HOD Election Reform Committee report back to the HOD at the 2019 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: 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 ⁸ 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:

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.


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; 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, encourage a healthy relationship between researchers and the community, and may reduce stigma associated with certain disease states; 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; 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; 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; 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; 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
RESOLVED, That our American Medical Association encourage the use of person-centered 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:

Whereas, Malignant melanoma is now the fifth most common cancer in the United States, and its incidence has increased 33-fold since 1935, with sun exposure being the principle cause;\(^1, 2, 3, 4\)

Whereas, The Surgeon General’s “Call to Action to Prevent Skin Cancer” of 2014\(^5\) concisely outlined the magnitude of the public health problem which skin cancer represents in this country, and recommended multiple strategies to decrease the risk of this preventable cancer, including special attention to the provision of shade structures in the planning of public and private spaces; and

Whereas, Shade structures are often treated as accessory buildings in planning and zoning matters, and this can result in the denial of reasonable shade protection in public and private spaces; therefore be it

RESOLVED, That our American Medical Association support sun shade structures (such as awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical importance of 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: 71-86
3. Skin Cancer Foundation Journal Vol 29; 65-67
5. The Surgeon Generals Call to Action to Prevent Skin Cancer 2014