



MEMBERSHIP
**MOVES
MEDICINE™**

HOUSE OF DELEGATES HANDBOOK

2018 INTERIM MEETING

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



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

MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

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

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

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

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



UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FOLLOWING COLLATED BY REFERRAL

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

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

11. 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.

SEATING ALLOCATION – 2018 INTERIM MEETING

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

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

ARS – 1
American Rhinologic Society (ARS) - 1

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

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

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

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

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

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

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

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

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

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

HEART OF AMERICA - 8
Kansas - 3
Missouri - 5

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TERRITORIES - 2
Guam - 1
Virgin Islands - 1

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

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

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

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

TELLERS - 8

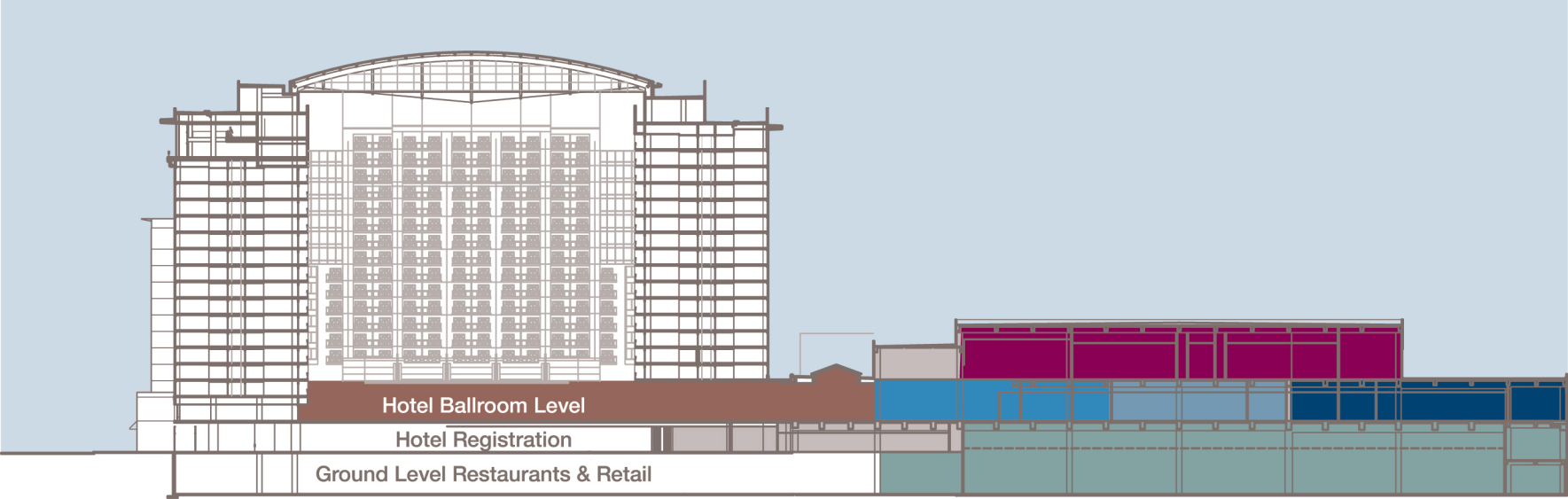
HOUSE OF DELEGATES · GAYLORD NATIONAL RESORT & CONVENTION CENTER, NATIONAL HARBOR, MARYLAND (I-18)

Audience Left

STAGE

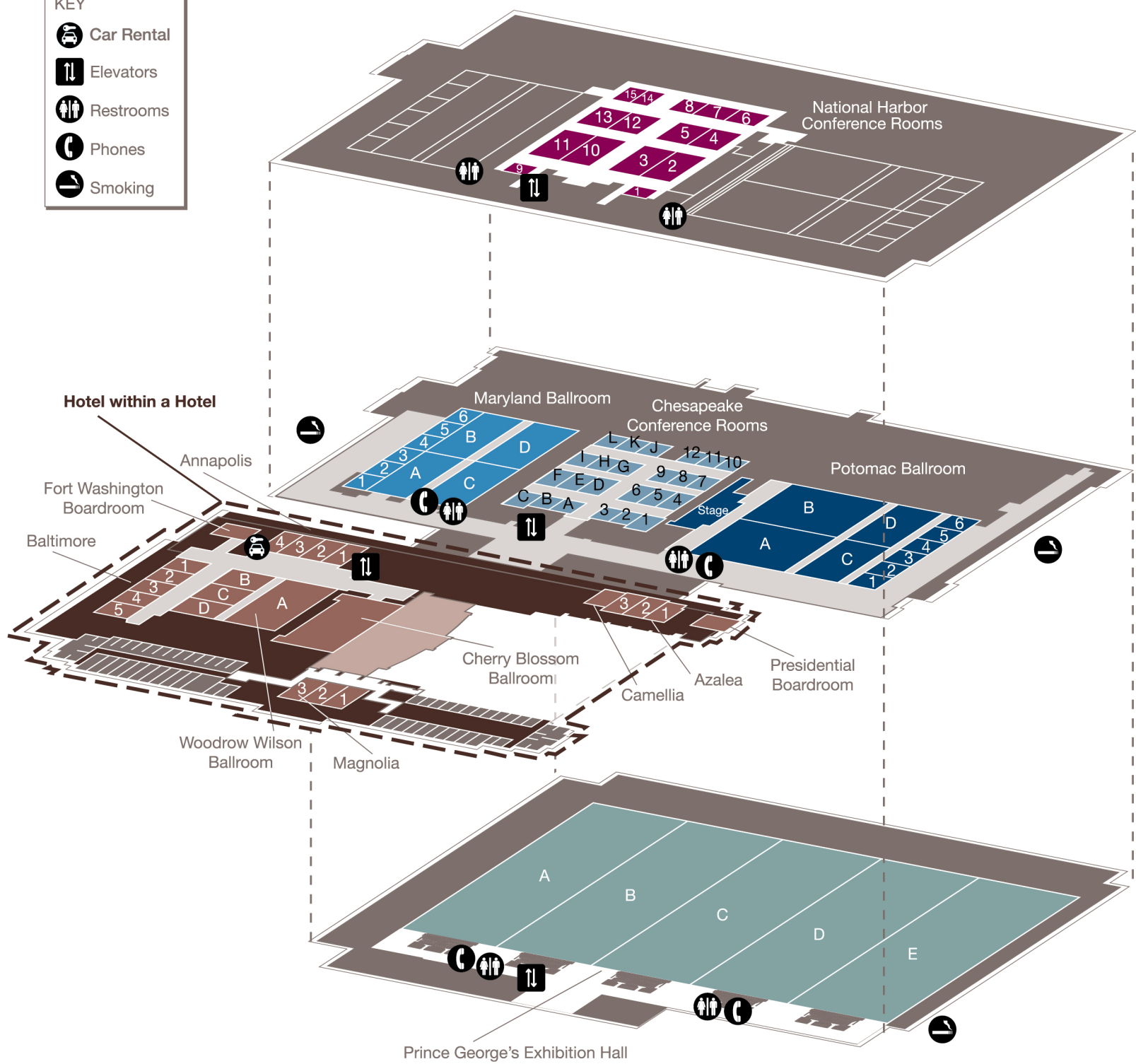
Audience Right

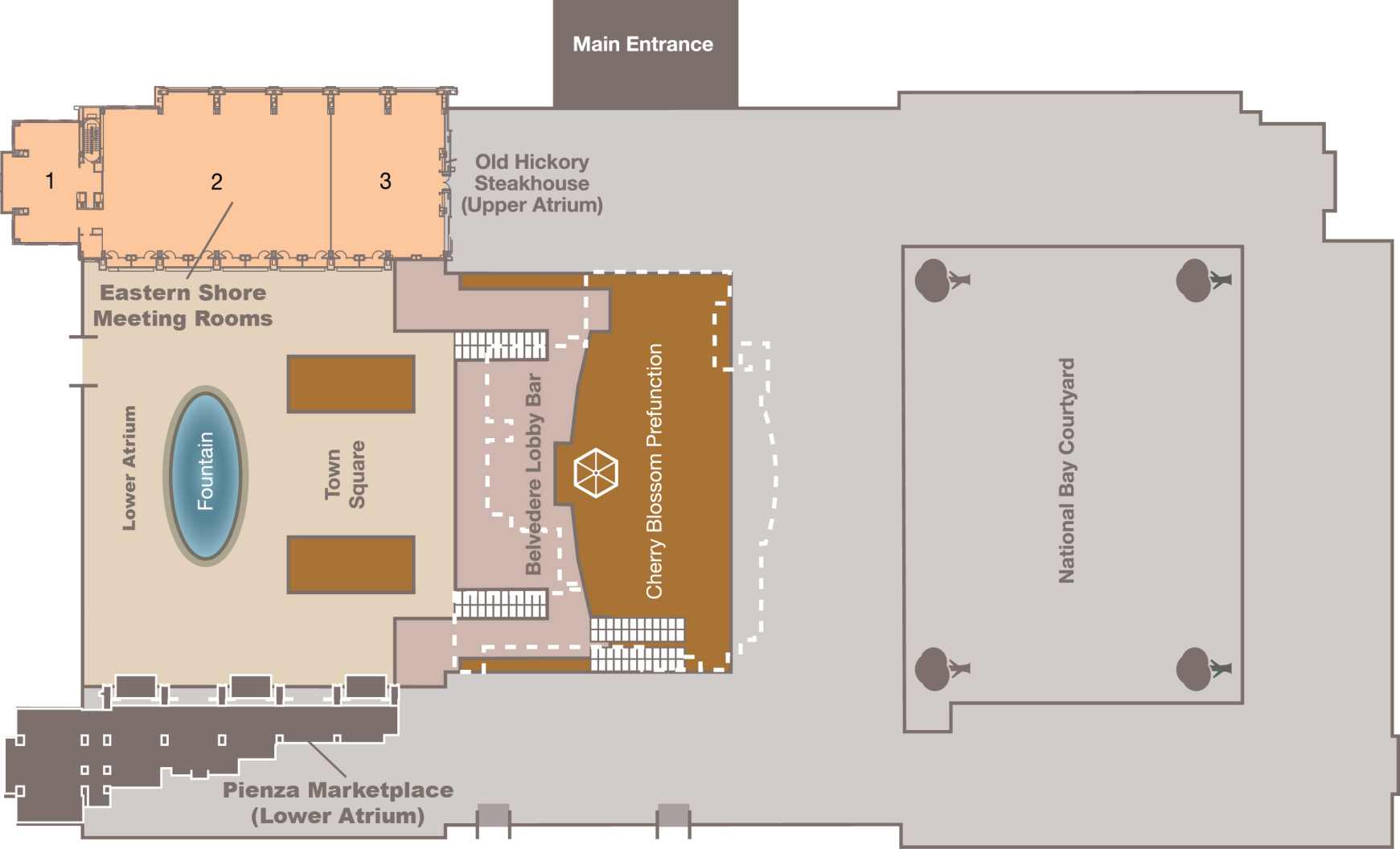
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KEY

- Car Rental
- Elevators
- Restrooms
- Phones
- Smoking





Main Entrance

1

2

3

Old Hickory
Steakhouse
(Upper Atrium)

Eastern Shore
Meeting Rooms

Lower Atrium

Fountain

Town
Square

Belvedere Lobby Bar



Cherry Blossom Prefunction

National Bay Courtyard

Pienza Marketplace
(Lower Atrium)

Fort Washington Boardroom

Business Center

To Convention Center
Ballroom Level

Annapolis

Camellia

Azalea

Presidential
Boardroom

Baltimore

Woodrow Wilson

Cherry Blossom
Ballroom

Ballroom
Lobby

(Lower Atrium)

Eastern Shore
Meeting Rooms

Magnolia

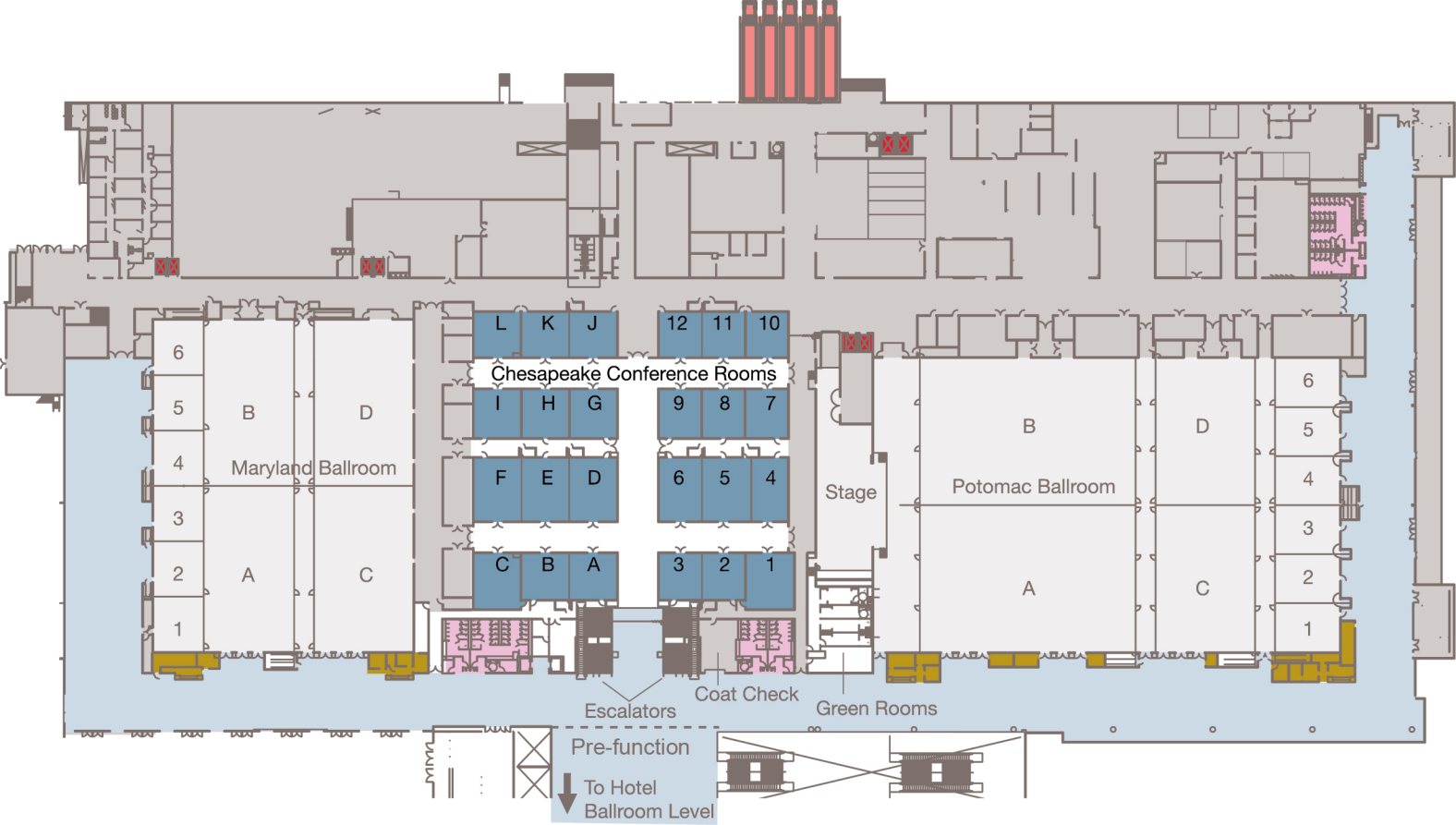


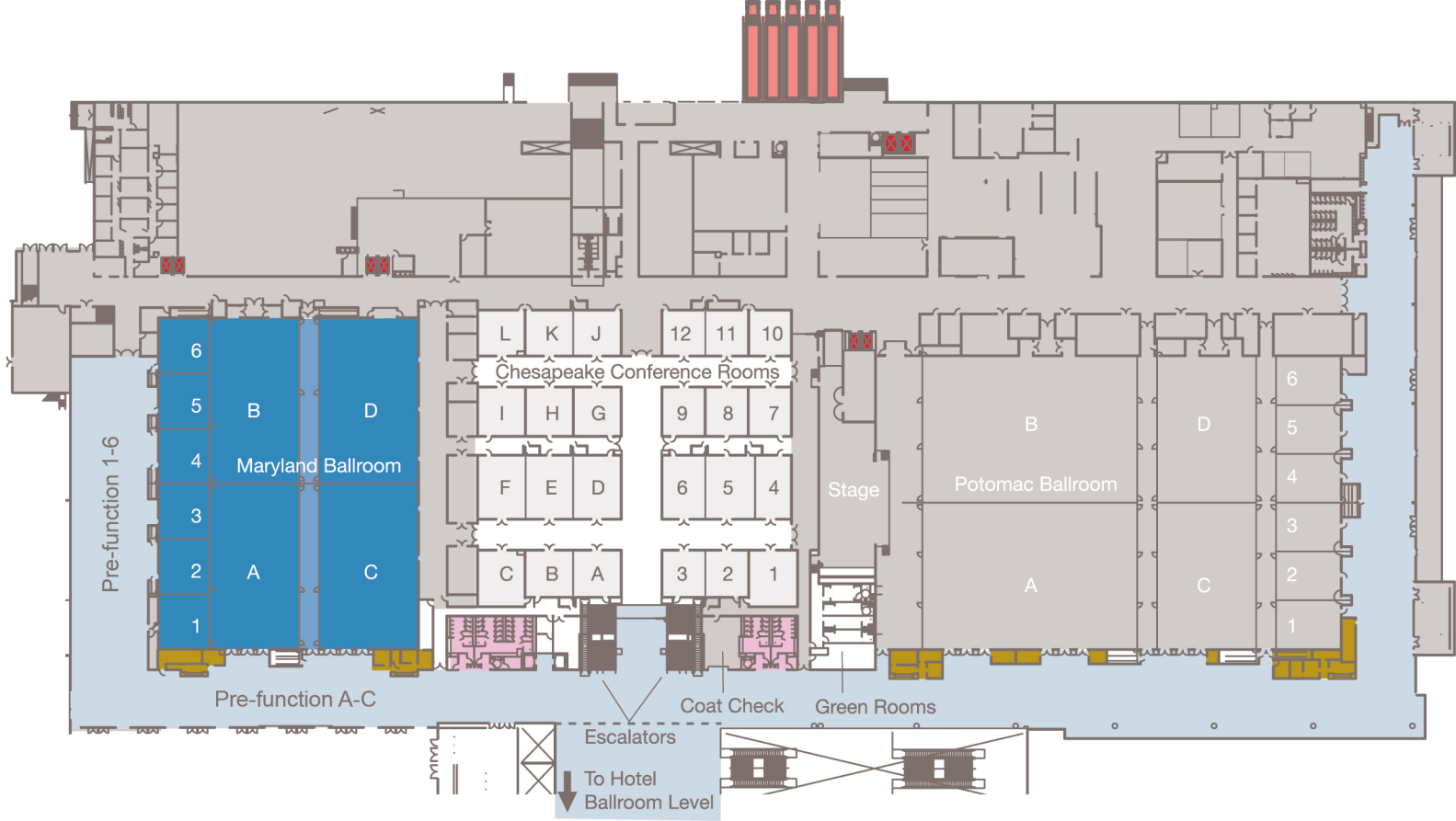
Fort Washington Boardroom

Business Center

To Convention Center
Ballroom Level







2018 INTERIM MEETING

REFERENCE COMMITTEE HEARING LOCATIONS

SUNDAY, NOVEMBER 11

8:30 am-Noon

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

2018 INTERIM MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

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

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

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

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

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

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

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

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

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

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

Barbara L. McAneny, MD
President

Susan R. Bailey, MD
Speaker, House of Delegates

Russell W.H. Kridel, MD
Secretary

2018-2019

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

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

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

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS

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

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

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

COUNCIL ON LEGISLATION

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

COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

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

Secretary: Susan Close, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION

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

Secretary: Carrie Radabaugh, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE

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

Secretary: Val Carpenter, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH

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

Secretary: Andrea Garcia, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE

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

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

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

Medical Association of the State of Alabama

Delegate(s)

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

Alternate Delegate(s)

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

Regional Medical Student Delegate(s)

Hannah M Ficarino, Mobile AL

Alaska State Medical Association

Delegate(s)

Alex Malter, Juneau AK

Alternate Delegate(s)

Mary Ann Foland, Anchorage AK

Arizona Medical Association

Delegate(s)

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

Alternate Delegate(s)

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

Regional Medical Student Delegate(s)

Adam Roussas, Tucson AZ

Regional Medical Student Alternate Delegate(s)

Sanjay Menghani, Vineland NJ

Arkansas Medical Society

Delegate(s)

Omar Atiq, Little Rock AR

Arkansas Medical Society

Delegate(s)

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

Alternate Delegate(s)

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

California Medical Association

Delegate(s)

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

Alternate Delegate(s)

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

This list does not reflect temporary changes for this meeting.

California Medical Association

Alternate Delegate(s)

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

Resident and Fellow Sectional Delegate(s)

Hunter Pattison, Sacramento CA

Resident and Fellow Sectional Alternate Delegate(s)

Jacob Burns, Sacramento CA

Regional Medical Student Delegate(s)

Rachel Ekaireb, San Francisco CA

Regional Medical Student Alternate Delegate(s)

Cecilia Leggett, San Diego CA
Neil Rens, Stanford CA

Colorado Medical Society

Delegate(s)

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

Alternate Delegate(s)

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

Resident and Fellow Sectional Delegate(s)

Luke V. Selby, Denver CO

Regional Medical Student Delegate(s)

Adam Panzer, Staten Island NY

Colorado Medical Society

Regional Medical Student Alternate Delegate(s)

Halea K Meese, Denver CO

Connecticut State Medical Society

Delegate(s)

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

Alternate Delegate(s)

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

Regional Medical Student Delegate(s)

Devin Bageac, Farmington CT

Regional Medical Student Alternate Delegate(s)

Kathryn Topalis, Simsbury CT

Medical Society of Delaware

Delegate(s)

Kelly S. Eschbach, Wilmington DE

Alternate Delegate(s)

Janice Tildon-Burton, Wilmington DE

Resident and Fellow Sectional Delegate(s)

Ankit Agarwal, Chapel Hill NC

Medical Society of the District of Columbia

Delegate(s)

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

Alternate Delegate(s)

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

Regional Medical Student Alternate Delegate(s)

Damani McIntosh-Clarke, Arlington VA

Florida Medical Association

Delegate(s)

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

This list does not reflect temporary changes for this meeting.

Florida Medical Association

Delegate(s)

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

Alternate Delegate(s)

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

Regional Medical Student Delegate(s)

Jessica Walsh O'Sullivan, Orlando FL

Regional Medical Student Alternate Delegate(s)

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

Medical Association of Georgia

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 Bishof, Forest Park IL
Scott A. Cooper, Chicago IL

This list does not reflect temporary changes for this meeting.

Illinois State Medical Society

Alternate Delegate(s)

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

Resident and Fellow Sectional Alternate Delegate(s)

Marla Rejbi, Chicago IL

Regional Medical Student Delegate(s)

Ajeet Singh, Forest Park IL

Regional Medical Student Alternate Delegate(s)

Ian Magruder, Wilmette IL

Indiana State Medical Association

Delegate(s)

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

Alternate Delegate(s)

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

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

Iowa Medical Society

Alternate Delegate(s)

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

Resident and Fellow Sectional Alternate Delegate(s)

Daniel Terveen, Iowa City IA

Kansas Medical Society

Delegate(s)

Terry L. Poling, Wichita KS
Arthur D. Snow, Shawnee Mission KS
Richard B. Warner, Shawnee Mission KS

Alternate Delegate(s)

Robert Gibbs, Parsons KS
James H. Gilbaugh, Wichita KS

Kentucky Medical Association

Delegate(s)

David J. Bensema, Lexington KY
J Gregory Cooper, Cynthiana KY
Bruce A. Scott, Louisville KY
Donald J. Swikert, Edgewood KY

Alternate Delegate(s)

Robert Couch, Louisville KY
Shawn C. Jones, Paducah KY
William B. Monnig, Crestview Hills KY
Robert A. Zaring, Louisville KY

Louisiana State Medical Society

Delegate(s)

Luis M. Alvarado, Mandeville LA
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Myo Myint, New Orleans LA
Lee Stevens, Shreveport LA

Alternate Delegate(s)

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Rachel Spann, New Orleans LA

Regional Medical Student Delegate(s)

Neal Dixit, New Orleans LA

Maine Medical Association

Delegate(s)

Richard A. Evans, Dover Foxcroft ME
Maroulla S. Gleaton, Augusta ME

This list does not reflect temporary changes for this meeting.

Maine Medical Association

Alternate Delegate(s)

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Robert Schlager, Pittsfield ME

MedChi: The Maryland State Medical Society

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Loralie Dawn Ma, Fulton MD
Shannon Pryor, Chevy Chase MD
Stephen J. Rockower, Rockville MD
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Massachusetts Medical Society

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Andrew Vallejo, Boston MA

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Nabiha Hashmi, Troy MI
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John A. Waters, Flint MI

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Nonie Arora, Ann Arbor MI

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Ravi S Johar, Maryland Heights MO
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Alternate Delegate(s)

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Nevada State Medical Association

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Peter R. Fenwick, Reno NV

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Neha Agrawal, Reno NV

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

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

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Medical Society of New Jersey

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

Regional Medical Student Delegate(s)

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

Regional Medical Student Alternate Delegate(s)

Priya Sushvet Kantesaria, Somerset NJ

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Stephen P. Lucero, Taos NM

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William Ritchie, Albuquerque NM
Sandra Lynn Whisler, Albuquerque NM

Medical Society of the State of New York

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Gregory L. Pinto, Saratoga Springs NY
Malcolm D. Reid, New York NY
Charles Rothberg, Patchogue NY
Joseph Sellers, Cobleskill NY
Corliss Varnum, Oswego NY

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Rose Berkun, Buffalo NY
Breyen Coffin, Bronx NY

Medical Society of the State of New York

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

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Raymond Lorenzoni, New York NY

Regional Medical Student Delegate(s)

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Ali Bokhari, Brooklyn NY

Regional Medical Student Alternate Delegate(s)

Michael Healey, Rochester NY
Rishi Thaker, Middletown NY

North Carolina Medical Society

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John R. Mangum, Sanford NC
Darlyne Menscer, Charlotte NC
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Regional Medical Student Delegate(s)

Lauren Benning, Littington 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

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

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

Resident and Fellow Sectional Delegate(s)

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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

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Sylvia Ann Emory, Eugene OR

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Mary McCarthy, Portland OR

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Virginia E. Hall, Hummelstown PA
Marilyn J. Heine, Dresher PA
Daniel B. Kimball, Wyomissing PA
Peter S. Lund, Fairview PA
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Judith R. Prybick, Allentown PA
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Scott E. Shapiro, Lower Gwynedd PA
John W. Spurlock, Coopersburg PA
Martin D. Trichtinger, Hatboro PA
John P. Williams, Gibsonia PA

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Mark Friedlander, Nabeth PA
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Aaron E. George, Chambersburg PA
Bruce A. MacLeod, Pittsburgh PA
Jill M. Owens, Bradford PA
Evan Pollack, Bryn Mawr PA
Rachel Thomas, Philadelphia PA
John Trickett, Jr., Scranton PA
John Michael Vasudevan, Philadelphia PA

Resident and Fellow Sectional Delegate(s)

Raghuveer Puttagunta, Danville PA

This list does not reflect temporary changes for this meeting.

Pennsylvania Medical Society

Regional Medical Student Delegate(s)

Nichole Ogojiaku, Marietta GA

Regional Medical Student Alternate Delegate(s)

Daniel Kim, Harrisburg PA

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

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Peter A. Hollmann, Cranston RI

Alternate Delegate(s)

Sarah Fessler, Riverside RI

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

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Stefanie M. Putnam, Mauldin SC
Alexander Ramsay, Charleston SC
John Ropp, III, Hartsville SC
Todd E Schlesinger, Charleston SC

Regional Medical Student Delegate(s)

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South Dakota State Medical Association

Delegate(s)

Mary Carpenter, Winner SD

Alternate Delegate(s)

Robert L. Allison, Pierre SD

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

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

Texas Medical Association

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

Alternate Delegate(s)

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

This list does not reflect temporary changes for this meeting.

Texas Medical Association

Alternate Delegate(s)

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

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Regional Medical Student Delegate(s)

Luis Seija, Temple TX

Regional Medical Student Alternate Delegate(s)

Sinan Ali Bana, Sugar Land TX
Robert Kotaki, McAllen TX
Aaron J Wolbrueck, Fort Worth TX

Utah Medical Association

Delegate(s)

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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

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Edward G. Koch, McLean VA
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Lawrence K. Monahan, Roanoke VA

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Clifford L. Deal, Henrico VA

Medical Society of Virginia

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Abby Winn, Roanoke VA

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Sheila D. Rege, Pasco WA
Rodney Trytko, Spokane WA

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

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Joseph Barry Selby, Morgantown WV

Alternate Delegate(s)

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

Wisconsin Medical Society

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Charles J. Rainey, River Hills WI
Paul A. Wertsch, Madison WI

Alternate Delegate(s)

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

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Wisconsin Medical Society

Alternate Delegate(s)

Keshni Ramnanan, Summit WI

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Michael Rigby, Madison WI

Regional Medical Student Alternate Delegate(s)

Nathan J Carptenter, Milwaukee WI

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Alternate Delegate(s)

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Delegate(s)

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Marta Jane Van Beek, Iowa City IA

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Alternate Delegate(s)

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Adam Rubin, Philadelphia PA

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Alternate Delegate(s)

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Daniel Heinemann, Canton SD

Kaci Larsen, Columbia MO

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Glenn Loomis, Hopewell Junction NY

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Janet West, Pensacola FL

Colette R. Willins, Avon OH

J. Mack Worthington, Chattanooga TN

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Samuel Mathis, Galveston TX

Julie K. Wood, Leawood KS

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Delegate(s)

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Delegate(s)

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Ann Murray, Morgantown WV

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Lisa Nijm, Warrenville IL

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Michael Suk, Danville PA

Kimberly Jo Templeton, Leawood KS

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

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Douglas R. Myers, Vancouver WA

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

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Susan Dixon McCammon, Galveston TX

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Alternate Delegate(s)

Donna Bloodworth, Alvin TX

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

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Carol Berkowitz, Rancho Palos Verdes CA

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Zarah Iqbal, Gladwyne PA

Colleen Kraft, Mission Viejo CA

Samantha Rosman, Jamaica Plain MA

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Susan L. Hubbell, Lima OH

Alternate Delegate(s)

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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.

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Delegate(s)

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American Association for Thoracic Surgery

Delegate(s)

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American Association of Clinical Endocrinologists

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Delegate(s)

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American Association of Neurological Surgeons

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Delegate(s)

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Alternate Delegate(s)

Enrica Arnaudo, Newark DE

American Association of Physicians of Indian Origin

Delegate(s)

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American Association of Physicians of Indian Origin

Alternate Delegate(s)

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American Association of Plastic Surgeons

Delegate(s)

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Alternate Delegate(s)

Michele Manahan, Baltimore MD

American Association of Public Health Physicians

Delegate(s)

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Alternate Delegate(s)

Arlene Seid, Grantham PA

American Clinical Neurophysiology Society

Delegate(s)

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Alternate Delegate(s)

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American College of Allergy, Asthma and Immunology

Delegate(s)

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M Eugene Sherman, Englewood CO

Suma Thomas, Cleveland OH

L. Samuel Wann, Whitefish Bay WI

Kim Allan Williams, Chicago IL

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David Winchester, Gainesville FL

Resident and Fellow Sectional Delegate(s)

Aaron Kithcart, Boston MA

American College of Chest Physicians (CHEST)

Delegate(s)

Neeraj Desai, Schaumburg IL

This list does not reflect temporary changes for this meeting.

American College of Emergency Physicians

Delegate(s)

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Brooks F. Bock, Vail CO
Stephen Epstein, Boston MA
Michael J. Gerardi, Hackettstown NJ
John C. Moorhead, Portland OR
Jennifer L. Wiler, Aurora CO

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Erick Eiting, New York NY
Vidor Friedman, Windermere FL
Reid Orth, Alexandria VA

American College of Gastroenterology

Delegate(s)

R Bruce Cameron, Chagrin Falls OH
March Seabrook, West Columbia SC

American College of Legal Medicine

Delegate(s)

Richard Wilbur, Lake Forest IL

American College of Medical Genetics & Genomics

Delegate(s)

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American College of Medical Quality

Delegate(s)

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American College of Mohs Surgery

Delegate(s)

Michel McDonald, Nashville TN

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Keena Que, Brookline MA

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Delegate(s)

Alan Klitzke, Buffalo NY

American College of Obstetricians and Gynecologists

Delegate(s)

Dana Block-Abraham, Baltimore MD

American College of Obstetricians and Gynecologists

Delegate(s)

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Joseph M. Heyman, West Newbury MA
Nita Kulkarni, Flint MI
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Barbara S. Levy, Washington DC
G. Sealy Massingill, Fort Worth TX
Diana Ramos, Laguna Beach CA
Brandi Ring, Denver CO
Kassandra Scales, Alexandria VA
Heather Smith, New York NY
Robert Wah, McLean VA

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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

SUMMARY OF FISCAL NOTES (I-18)

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: Modest
- 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

SUMMARY OF FISCAL NOTES (I-18)

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

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)

1 INTRODUCTION

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

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

9
10 RESOLVED, That our AMA's House of Delegates encourage the AMA Litigation Center to
11 provide such support to a constituent or component medical society whose members have been
12 sued for expressing good faith opinions regarding medical issues as the Litigation Center
13 deems appropriate in any specific case.

14
15 The reference committee heard testimony that physicians had been sued for expressing their
16 opinions on such politically sensitive issues as the treatment of chronic pain or the potential
17 benefits of medical marijuana. Physicians testified that these lawsuits are expensive, produce
18 anxiety, and impact physicians' willingness to speak publicly on controversial public issues. While
19 testimony generally supported the resolution, concerns were raised regarding the term "good faith,"
20 which the reference committee found to be "a complex and sensitive issue." The resolution was
21 referred to the Board of Trustees in order to investigate the optimal language needed to accomplish
22 the goals of Resolution 5.

23
24 This report is submitted in response to that referral. Notably, though, the scope of the House
25 referral and thus of this report is much narrower than the heading, "Protection of Physician
26 Freedom of Speech," might suggest. Physician freedom of speech encompasses far more than the
27 subject of Resolution 5. In conformity with the Board's interpretation of the request from the
28 House, this report is focused on the specific proposals of Resolution 5 and particularly on the term
29 "good faith."

30 31 FIRST RESOLVE

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

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

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

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

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

29 SECOND RESOLVE

30

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

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

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

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

7
8 RECOMMENDATION

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

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

Fiscal Note: Less than \$500

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;¹ 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;² and

Whereas, ACP improves respecting end-of-life wishes and patient and family satisfaction while reducing family member anxiety and stress;³⁻⁴ and

Whereas, Studies suggest that ACP is cost-effective in end-of-life care;⁵⁻⁶ and

Whereas, ACP documentation varies by state and region and is often difficult to locate;⁷⁻¹⁰ 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

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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)

1 INTRODUCTION

2
3 At the 2017 Interim Meeting, the House of Delegates referred Resolution 208-I-17, "Increased Use
4 of Body-Worn Cameras by Law Enforcement Officers," introduced by the Medical Student
5 Section, which asked:

6
7 That our American Medical Association advocate for legislative, administrative, or regulatory
8 measures to expand funding for (1) the purchase of body-worn cameras and (2) training and
9 technical assistance required to implement body-worn camera programs.

10
11 The reference committee heard testimony largely in support of referral. Testimony emphasized the
12 use of body-worn cameras by law enforcement officers was a matter of public health and directly
13 related to existing American Medical Association (AMA) policy concerning the health of
14 minorities. Others expressed concern that the issues being raised were outside of the expertise and
15 scope of our AMA. The reference committee recommended referral in order to address all concerns
16 raised by Resolution 218. This Board report provides background, discussion of body-worn
17 cameras by law enforcement officers, and a recommendation.

18 19 BACKGROUND

20
21 Following a number of high-profile incidents involving deadly force used against minorities, law
22 enforcement agencies have increasingly adopted body-worn cameras for their officers. Often
23 affixed to the torso, body-worn cameras are small, wearable audio, video or photographic recording
24 systems that record events in which law enforcement officers are involved. The recordings can be
25 used to demonstrate transparency to the community, to document events and to deter inappropriate,
26 illegal or unethical behavior by both the wearer of the camera and the public.

27
28 To date, 34 states and the District of Columbia have enacted laws governing the use of body-worn
29 cameras by law enforcement, though not all law enforcement departments utilize cameras in the
30 same manner.¹ For example, some permit officers to turn off the devices under certain
31 circumstances; others do not. In addition, a 2016 survey of large police departments nationwide
32 found that 95 percent intended to implement or had already implemented a body camera program.
33 According to the survey, 18 percent had fully operational programs.²

34
35 The cost to law enforcement entities to implement and maintain a body camera program can be
36 costly and is an ongoing expense. Implementing a program requires an initial capital outlay to

1 purchase the technology and ancillary equipment; law enforcement agencies must account for
2 continuing operational costs, such as training on use, data storage, software and staff and
3 operational costs required for reviewing the recordings, redacting as necessary, and providing
4 recordings to courts and the public as appropriate. In Washington, DC, for example, the city spent
5 over \$1 million outfitting 2,800 officers and expects operating costs to top \$2 million per year.³
6

7 In 2015, the U.S. Department of Justice (DOJ) Bureau of Justice Assistance (BJA) awarded
8 \$22.5 million in grant assistance to state and local law enforcement departments as part of the
9 Body-Worn Camera Pilot Implementation Program. The Consolidated Appropriations Act, 2018
10 appropriated \$22.5 million for a competitive matching grant program for purchases of body-worn
11 cameras for state, local and tribal law enforcement. The BJA expects to make up to 28 awards for a
12 three-year period, to begin on October 1, 2018. State and local funding is also available for
13 body-worn cameras.
14

15 DISCUSSION

16

17 Predicated on whether the AMA ought to support funding of body camera programs is the question
18 of whether the AMA ought to support the expanded use of body cameras and whether the devices
19 achieve their intended outcomes.
20

21 *Policing Activity*

22

23 The underlying theory in support of body-worn cameras is that both officers and members of the
24 community will change their behaviors for the better if their actions are being recorded. Indeed, a
25 large body of research suggests that people act differently when they believe they are being
26 watched. In the context of law enforcement, body-worn cameras are expected to increase self-
27 awareness and thus deter unprofessional, inappropriate and illegal behavior by officers and
28 civilians alike. As law enforcement officers are more likely to use force against minority
29 community members, many hope body-worn cameras will improve policing behavior toward
30 minorities, using force only when warranted and de-escalation tactics have failed.^{4,5} In cases where
31 law enforcement officers do use force, body-worn cameras offer contemporaneous evidence of the
32 officers' actions so that improper behavior can be disciplined. Evidence about the impact of
33 cameras on policing activity generally, though not universally, supports this theory.
34

35 An early study conducted in the Rialto, California police department found use-of-force incidents
36 declined 58.3 percent over a three-year period after a body camera program was implemented.⁶
37 Importantly, researchers later found that use of force rates were higher in the same Rialto,
38 California police force despite the presence of a camera when officers were allowed discretion to
39 turn off cameras.⁷ Another randomized controlled trial conducted between 2014 and 2015 in the
40 Las Vegas Metropolitan Police Department found that officers wearing body cameras were
41 12.5 percent less likely to be involved in a use of force incident.⁸ Similar results were found in
42 Orlando, Florida.⁹ In contrast, the largest randomized controlled study to date, conducted in 2015
43 with the Metropolitan Police Department of the District of Columbia, found no statistically
44 significant difference in the rates of police use of force.¹⁰
45

46 Research has found mixed results about other forms of police activity. In the study conducted in
47 Las Vegas, body camera use was not associated with a change in the number of police-community
48 interactions, but body cameras were associated with a 6.8 percent increase in the number of
49 citations issued and a 5.2 percent increase in the number of events that resulted in an arrest. A 2015
50 study conducted in Mesa, Arizona found officers wearing a camera were less likely to perform
51 stop-and-frisks and make arrests, but were more likely to give citations and initiate encounters.¹¹ In

Phoenix, Arizona use of body-worn cameras were associated with a 17 percent increase in arrests.¹² However, other studies have found body-worn cameras are associated with slightly lower incidents of arrest.¹³

Community Relations

Changing policing behaviors is not the only way body-worn cameras could provide benefits. Many communities and law enforcement agencies see body cameras as a valuable way to improve policing transparency and community relations. Indeed, in 2015 when DOJ grants were announced, then-US Attorney General Loretta Lynch stated that body-worn cameras hold “tremendous promise for enhancing transparency, promoting accountability, and advancing public safety for law enforcement officers and the communities they serve.”¹⁴ Body cameras are lauded as a way for the public to better understand what transpires between law enforcement officers and civilians. Officers may also view body cameras positively, as recordings demonstrate to the community the difficult and dangerous job required of them.

Few studies have taken a comprehensive look at community attitudes toward police after the introduction of body-worn cameras.¹⁵ One such study conducted by the Urban Institute found that body-worn cameras do improve community members’ satisfaction with police encounters.¹³ Another study found that individuals viewed officers as having greater legitimacy, professionalism and satisfaction, but did not find significant differences between citizens’ perceptions of officers depending on whether the officer was wearing a camera.¹⁶

The evidence is clearer, however, that body-worn cameras are associated with decreased rates of complaints filed against law enforcement officers. For example, one early study found complaints against officers dropped 88 percent following implementation of a body cameras program.⁶ In Rialto, California, citizen complaints declined by 60 percent. In the Las Vegas Metropolitan Police, officers wearing body cameras were 14 percent less likely to be the subject of a citizen complaint.⁸ In Phoenix, complaints against officers who wore the cameras declined by 23 percent, compared to a 10.6 percent increase among comparison officers.¹² In contrast, research in the District of Columbia found no statistically significant difference in the rates of civilian complaints.

The available evidence does not identify the underlying behavioral changes responsible for the decline in complaint rates, however. It may be that body-worn cameras have the intended effect of changing officer behavior for the better, thus reducing circumstances that warrant citizen complaints. It may be that cameras have a “civilizing” effect on members of the public as well. Some evidence also suggests that frivolous complaints are less likely to be filed when recordings are available.¹⁵

It is important to note, however, that use of body cameras will not automatically foster greater trust between law enforcement and members of the community and should not be viewed, as one evaluation noted, as a “plug-and-play” solution.¹⁰ Notably, the Urban Institute found body-worn cameras improved community satisfaction to a lesser extent than did procedurally just practices, defined in that study as behaving fairly and acting with empathy.¹³

Privacy Considerations

Though the use of body cameras promises greater transparency of law enforcement behavior and actions, they also present new problems, namely intrusion into the privacy of victims, witnesses and bystanders. For instance, law enforcement officers frequently enter individuals’ homes and in-home recordings would become part of the public record. Similarly, interactions and conversations

with victims and witnesses could make those individuals uncomfortable or put those individuals in danger. Heavily policed communities – often minority communities – will be more heavily recorded.

These privacy concerns could be addressed with policies to limit recording during such encounters and by limiting the circumstances under which recordings are made available to the public. The American Civil Liberties Union (ACLU) recommends use of body cameras with significant privacy protections. Officer privacy may also be a concern. Some law enforcement unions have opposed body-worn cameras, arguing that adoption of the technology must be negotiated as part of the collective bargaining agreement.

This report acknowledges the significant privacy concerns raised by the ubiquitous use of body-worn cameras, but notes that questions about when cameras need to be turned on and off, how long to keep footage, when recordings will be made publicly available and other policy details are beyond the expertise of the AMA.

Nexus with the AMA's Mission

The AMA does not have policy specifically addressing the use of body-worn cameras among law enforcement. During the debate over Resolution 208 during the 2017 Interim Meeting, the reference committee heard testimony questioning whether this topic is within the scope of the AMA's expertise. This concern is reasonable, as AMA has not historically delved into issues of policing and significant resources would be required to bring the AMA into the public policy debates surrounding community policing efforts. Further, while there are dozens of organizations (the Police Executive Research Forum, Leadership Conference on Civil and Human Rights, ACLU, etc.) that are actively engaged on this issue, it does not appear that any other major medical associations have emerged as significant stakeholders.

Nevertheless, there is a connection between health and police activity, particularly in terms of minority fatality rates. Research has demonstrated that minority communities are disproportionately subject to police force. Specifically, according to an analysis of FBI statistics, African-Americans account for 31 percent of police-involved shootings, but comprise 13 percent of the U.S. population.⁴ African-American males are particularly at risk. According to another analysis, African-American males are three times more likely to be killed by police than non-Hispanic white males.⁵

Research has also shown a correlation between policing and other health outcomes. In particular, a recent study found that police killings of unarmed African-Americans were associated with 1.7 days of poor mental health annually among African-Americans. The findings were seen regardless of whether the individual affected had a personal relationship with the victim or whether the incident was experienced vicariously. In addition, the numbers of police stops, coupled with the level of invasiveness during police encounters, is associated with increased levels of stress and anxiety.^{17,18} African-American men report more anxiety and post-traumatic stress disorder and more morbidity from these psychiatric conditions than Caucasian men.⁵ In addition, research of data from the New York Police Department revealed that residents in neighborhoods with higher rates of stop-and-frisks were more likely to be in poor health, measured in terms of high blood pressure, diabetes, asthma and self-rated health.¹⁸ Research on the correlation between health and policing, however, remains sparse and warrants further research.

1 RELEVANT AMA POLICIES

2
3 Existing AMA policy does not address the use or funding of body-worn cameras. However, AMA
4 policy does state that physical or verbal violence between law enforcement officers and the public,
5 particularly within ethnic and racial minority communities, is a social determinant of health and
6 supports research into the public health effects of violent interactions. (H-515.955) In addition,
7 Policy H-350.971 “AMA Initiatives Regarding Minorities” instructs the AMA to establish a
8 mechanism to facilitate the development and implementation of a comprehensive, long-range,
9 coordinated strategy to address issues and concerns affecting minorities, including minority health.

10
11 New policy adopted during the 2018 Annual Meeting encourages states to require the reporting of
12 legal intervention deaths and law enforcement officer homicides to public health agencies. New
13 policy also encourage appropriate stakeholders, including law enforcement and public health
14 communities, to define “serious injuries” for the purpose of systematically collecting data on law
15 enforcement-related non-fatal injuries among civilians and officers.

16
17 Additionally, Policy H-145.977 “Use of Conducted Electrical Devices by Law Enforcement
18 Agencies” cautions against excessive use of conducted electrical devices (often called Tasers) and
19 recommends that law enforcement departments and agencies should have in place specific
20 guidelines, rigorous training and an accountability system for the use of conducted electrical
21 devices. AMA policy recommends research into the health impacts of conducted electrical device
22 use and development of a standardized protocol developed with the input of the medical
23 community for the evaluation, management and post-exposure monitoring of subjects exposed to
24 conducted electrical devices.

25
26 RECOMMENDATION

27
28 The Board recommends that the following be adopted in lieu of Resolution 208-I-17, and that the
29 remainder of the report be filed.

30
31 That our American Medical Association work with interested state and national medical
32 specialty societies to support state legislation and/or regulation that would encourage the use of
33 body-worn camera programs for law enforcement officers and fund the purchase of body-worn
34 cameras, training for officers and technical assistance for law enforcement agencies.

Fiscal Note: Less than \$5,000

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-I-18

Subject: Exclusive State Control of Methadone Clinics
(Resolution 211-I-17)

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

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 INTRODUCTION

2
3 At the 2017 Interim Meeting, the House of Delegates referred Resolution 211-I-17, “Exclusive
4 State Control of Methadone Clinics,” introduced by the Indiana Delegation, which asked:

5
6 That our American Medical Association support complete state control of all aspects of
7 methadone clinic approval and operations; and, if deemed necessary, this control could be
8 granted on a state by state basis.
9

10 Reference committee testimony generally was mixed and noted that there is likely both a state and
11 federal role as it relates to methadone clinic approval and operations. Delegates encouraged further
12 study, including discussion about methadone clinic reporting to state prescription drug monitoring
13 programs (PDMP). This report reviews existing information, provides background and presents
14 recommendations.
15

16 DISCUSSION

17
18 Your Board strongly agrees with the authors of Resolution 211-I-17 that methadone clinics provide
19 a valuable service to patients with an opioid use disorder. Methadone maintenance therapy (MMT)
20 for the treatment of opioid use disorder has been used for more than 40 years to help patients,
21 having been approved in 1972 by the U.S. Food and Drug Administration (FDA) for treatment of
22 heroin addiction. The health and safety of methadone has been studied extensively and ample
23 evidence exists supporting its use to aid in mortality and crime reduction.¹
24

25 There are more than 1,600 certified opioid treatment programs (OTPs) offering methadone in the
26 U.S.² According to the Substance Abuse and Mental Health Services Administration (SAMHSA),
27 the number of persons receiving methadone increased by 34 percent from 2006 (258,752) to
28 2016 (345,443).³ With respect to opioid-related mortality, deaths attributed to methadone increased
29 rapidly from 1999 (784 deaths) to their peak in 2007 (5,518) and have steadily declined since with
30 3,373 methadone-related deaths in 2016, according to the Centers for Disease Control and
31 Prevention.⁴ It is beyond the scope of this report to detail whether the methadone use in these
32 deaths was for the treatment of pain, for opioid use disorder, related to illicit use or was a
33 complicating polypharmacy factor.
34

35 The FDA, U.S. Drug Enforcement Administration (DEA), U.S. Department of Health and Human
36 Services (HHS) and states each have a role to play in the oversight and administration of MMT.

FDA Regulatory Authority

Within the broad scope of FDA's regulatory authority is the review and approval of drugs, both brand name and generic. A general overview of the FDA process can be found online: <https://www.fda.gov/Drugs/DevelopmentApprovalProcess/default.htm#FDA>. With respect to methadone, the FDA approved a New Drug Application for methadone in 1947. There were intervening actions, but for the purposes of this report, the FDA issued regulations for methadone Investigational New Drugs in 1971; proposed new regulations in April 1972; and issued final regulations in December 1972.⁵

DEA Regulatory Authority

DEA authority with respect to methadone focuses on the medication's classification as a Schedule II controlled substance.⁶ Included within DEA's responsibilities is the "enforcement of the provisions of the Controlled Substances Act as they pertain to the manufacture, distribution, and dispensing of legally produced controlled substances." As a controlled substance, methadone falls within this scope.

HHS Regulatory Authority

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), a division within HHS, has broad regulatory authority concerning MMT and opioid treatment programs (OTP). This includes the authority to certify OTPs, which is defined as "a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication registered under 21 USC 823(g)(1)."⁷

Regulations concerning OTPs, where patients receive MMT (and other medications and treatments), provide guidance for numerous issues. These issues include accreditation of opioid treatment programs, certification and treatment standards for OTPs, procedures for review of suspension or proposed revocation of OTP certification, and of adverse action regarding withdrawal of approval of an accreditation body, and more.⁸

Specifically related to methadone, 42 CFR Part 8 provides that "methadone shall be administered or dispensed only in oral form and shall be formulated in such a way as to reduce its potential for parenteral abuse." It also provides that:

For each new patient enrolled in a program, the initial dose of methadone shall not exceed 30 milligrams and the total dose for the first day shall not exceed 40 milligrams, unless the program physician documents in the patient's record that 40 milligrams did not suppress opioid abstinence symptoms.

There also are requirements for frequency of patients receiving toxicology tests, treatment of pregnant patients, requirements for take-home doses of methadone, and more.⁹

State Authority

There are numerous areas where state regulatory authority and linkages with federal oversight exist regarding OTPs. One prominent area concerns who shall serve as the medical director of the OTP. Federal regulations require that the medical director must be "a physician licensed to practice medicine in the jurisdiction in which the [OTP] is located." State licensure is squarely within the exclusive control of state licensing boards. Federal regulations also require that there are adequate

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

6
7 SAMHSA also has recognized the clear need for OTPs to work with leaders in the community to
8 ensure comprehensive support services. That is, to support/encourage collaborative, multiagency
9 surveillance efforts to obtain timely and comprehensive data to target interventions and inform
10 prevention and response efforts. This includes working with the community to help determine
11 where an OTP is most needed; how an OTP can be integrated into the community with the least
12 impact on neighborhoods and traffic, for example; how to help educate the community on the
13 benefits of treatment for opioid use disorder so as to reduce stigma; and other areas.¹¹

14
15 Another area of state control—which raises potential conflicts with federal law—concerns whether
16 OTPs should be required to report methadone dispensing information to the state PDMP. This issue
17 is extremely controversial. In fact, while this issue was raised by the resolution that gave rise to this
18 report, it also was raised in Resolution 507 from the 2018 Annual Meeting. Resolution 507-A-18
19 was referred for further study of a more extensive range of privacy and clinical issues relating to
20 PDMPs and OTPs. Given that your Board is currently deliberating on Resolution 507-A-18, and
21 the fact that SAMHSA has not specifically resolved the many issues associated with reporting OTP
22 information to state PDMPs,¹² your Board believes it would be prudent to delay further comment
23 here so as not to cause confusion with pending research and discussions. Your Board does note,
24 however, that our AMA continues to urge physicians to use PDMPs to help inform their clinical
25 decision making. There is nothing to prevent physicians and other health care professionals in an
26 OTP from checking the state PDMP to ensure a patient is not receiving prescriptions for controlled
27 substances from other providers. Whether an OTP should report to a PDMP, however, is a matter
28 of federal—not state—jurisdiction.

29
30 Additional areas where states can help complement the medical care provided at OTPs include
31 promotion of take-home naloxone (governed by state law); education that helps remove the stigma
32 associated with MMT and medication assisted treatment (MAT); working toward policies that
33 remove health insurance and pharmacy benefit management company barriers to receiving MMT
34 and MAT (e.g., prior authorization, network adequacy for mental health care); prompt and accurate
35 overdose reporting for surveillance efforts related to prevention, treatment, and response;
36 identification of linkages within the community to peer counseling and other support services, to
37 name a few.

38
39 Furthermore, to complement and assist OTPs with the federal requirement to help an OTP identify
40 and prevent patients from enrolling in multiple OTPs concurrently, states can develop
41 communications and other tools to help OTPs (and other health care providers) identify all OTPs
42 doing business in a state and in surrounding areas. Federal rules already require an OTP to take
43 reasonable measures to do this. It seems reasonable that this would be an area where the state,
44 working with health insurance companies and other payers, as well as with the medical community,
45 would be well-advised to develop such a mapping/informational tool. This would not only allow
46 OTPs to more easily communicate with each other, but it would help patients identify where OTPs
47 exist in the state.

48
49 In Indiana, for example, the federal OTP locator maintained by SAMHSA identifies 16 OTPs
50 operating in the state,¹³ but it does not allow for multiple states to be displayed simultaneously. The
51 SAMHSA locator also does not allow for multiple OTPs within the state to be displayed

1 simultaneously. While the AMA appreciates the technical and other challenges that may be present
2 in maintaining and keeping a current list of OTPs, creating a more robust OTP locator tool may be
3 an area where state-based expertise and multistate partnerships can tailor solutions so that patients
4 and physicians would be able to more easily locate and communicate with OTPs.

5 6 AMA POLICY

7
8 Relevant AMA policy provides for strong support of access to methadone. This includes MMT
9 used in combination with behavioral and social supports, as well as support for physicians and
10 organized medicine to provide education and training regarding treatment of substance use
11 disorders (Policy H-95.957, “Methadone Maintenance in Private Practice;” Policy D-120.985,
12 “Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of
13 Methadone”). AMA policy also calls for continued funding of OTPs operating in states (Policy
14 D-95.999, “Reduction of Medical and Public Health Consequences of Drug Abuse: Update”); and
15 for the AMA to “advocate for legislation that eliminates barriers to, increases funding for, and
16 requires access to all appropriate FDA-approved medications or therapies used by licensed drug
17 treatment clinics or facilities” (Policy D-95.968, “Support the Elimination of Barriers to
18 Medication-Assisted Treatment for Substance Use Disorder”). AMA policy also clearly supports
19 MAT in correctional settings and in the community in conjunction with counseling (Policy
20 H-430.987, “Opiate Replacement Therapy Programs in Correctional Facilities”).

21
22 AMA policy also calls for continued funding of OTPs operating in states (Policy D-95.999,
23 “Reduction of Medical and Public Health Consequences of Drug Abuse: Update”); and for the
24 AMA to “advocate for legislation that eliminates barriers to, increases funding for, and requires
25 access to all appropriate FDA-approved medications or therapies used by licensed drug treatment
26 clinics or facilities” (Policy D-95.968, “Support the Elimination of Barriers to Medication-Assisted
27 Treatment for Substance Use Disorder”).

28
29 AMA policy also provides, in part, that “local communities or regions should exercise the
30 responsibility for assessing their needs with respect to the type, size, scope, and location of health
31 care facilities. State governments should ensure that needs of the underserved are being met
32 satisfactorily without wasteful duplication” (Policy H-205.992, “Supply and Distribution of Health
33 Care Facilities”).

34 35 RECOMMENDATIONS

36
37 The Board recommends that the following recommendation be adopted in lieu of Resolution 211-I-
38 17, and that the remainder of the report be filed.

- 39
40 1. That our American Medical Association (AMA) support the right of federally certified Opioid
41 Treatment Programs (OTPs) to be located within residential, commercial and any other areas
42 where there is a demonstrated medical need; (New HOD Policy)
43
44 2. That our AMA encourage state governments to collaborate with health insurance companies
45 and other payers, state medical societies, national medical specialty societies, OTPs and other
46 health care organizations to develop and disseminate resources that identify where OTP
47 providers operate in a state and take part in surveillance efforts to obtain timely and
48 comprehensive data to inform treatment opportunities; and (New HOD Policy)

- 1 3. That our AMA advocate for the federal agencies responsible for approving opioid treatment
- 2 programs to consider the views of state and local stakeholders when making decisions about
- 3 OTP locations and policies. (New HOD Policy)

Fiscal Note: \$2,500

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- ² Opioid Treatment Program Directory. Substance Abuse and Mental Health Services Association. Available at <https://dpt2.samhsa.gov/treatment/directory.aspx>
- ³ U.S. Department Of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS): 2016 Data on Substance Abuse Treatment Facilities. Available at https://www.samhsa.gov/data/sites/default/files/2016_NSSATS.pdf
- ⁴ Opioid Overdose Deaths by Type of Opioid. Kaiser Family Foundation analysis of CDC data. Available at <https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-type-of-opioid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
- ⁵ For a thorough discussion of the history of methadone regulation, see Institute of Medicine (US) Committee on Federal Regulation of Methadone Treatment; Rettig RA, Yarmolinsky A, editors. Federal Regulation of Methadone Treatment. Washington (DC): National Academies Press (US); 1995. 5, Federal Regulation of Methadone Treatment. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK232105/>
- ⁶ Methadone drug summary. Drug Enforcement Administration Office of Diversion Control Drug & Chemical Evaluation Section. Available at https://www.deadiversion.usdoj.gov/drug_chem_info/methadone/methadone.pdf
- ⁷ 42 CFR Part 8, available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=3&SID=7282616ac574225f795d5849935efc45&ty=HTML&h=L&n=pt42.1.8&r=P&ART#se42.1.8_12
- ⁸ 42 CFR Part 8, available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=3&SID=7282616ac574225f795d5849935efc45&ty=HTML&h=L&n=pt42.1.8&r=P&ART#se42.1.8_12
- ⁹ 42 CFR Part 8.12
- ¹⁰ Examples of a zoning board denying the opening of a methadone clinic: “Philadelphia zoning board denies methadone clinic for northeast neighborhood,” <https://whyy.org/articles/zone14>/<https://whyy.org/articles/zone14/>; “Zoning Board denies Rochester methadone clinic’s appeal,” <http://www.fosters.com/news/20180314/zoning-board-denies-rochester-methadone-clinics-appeal>; “Proposed methadone clinic denied by Rockford committee,” <http://www.wifr.com/content/news/Proposed-Methadone-Clinic-Denied-by-Rockford-Committee-487830091.html>
- ¹¹ See Federal Guidelines for Opioid treatment Programs. Substance Abuse and Mental Health Services Administration. January 2015. Available at <https://store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf>
- ¹² Confidentiality of Substance Use Disorder Patient Records, U.S. Department of Health and Human Services. Final Rule. January 18, 2017. Available at <https://www.federalregister.gov/documents/2017/01/18/2017-00719/confidentiality-of-substance-use-disorder-patient-records>
- ¹³ Opioid Treatment Program Directory, SAMHSA, <https://dpt2.samhsa.gov/treatment/directory.aspx>

REPORT OF THE BOARD OF TRUSTEES

B of T Report 7-I-18

Subject: Advocacy for Seamless Interface Between Physicians Electronic Health Records (EHRs), Pharmacies and Prescription Drug Monitoring Programs (PDMPs) (Resolution 212-A-17; BOT Report 12-A-18)

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

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 INTRODUCTION

2
3 At the 2017 Annual Meeting, the American Medical Association (AMA) House of Delegates
4 (HOD) referred Resolution 212-A-17, submitted by the American College of Legal Medicine
5 (ACLM). The resolution asked that our AMA:

6
7 Join the American College of Legal Medicine to advocate federally-mandated interfaces
8 between provider/dispenser electronic health record systems in the clinical, hospital and
9 pharmacy environments and state prescription drug databases and/or prescription drug
10 management plans;

11
12 Advocate that the cost of generating these interfaces be borne by the commercial EHR and
13 dispensing program providers;

14
15 Advocate that the interface should include automatic query of any opioid prescription, from a
16 provider against the state prescription drug database/prescription drug management plan
17 (PDMP) to determine whether such a patient has received such a medication, or another
18 Schedule II drug from any provider in the preceding ninety (90) days;

19
20 Advocate that the prescriber and the patient's EHR-listed dispensing pharmacy should then be
21 notified of the existence of the referenced patient in the relevant PDMP database, the substance
22 of the previous prescription(s) (including the medication name, number dispensed and
23 prescriber's directions for use) in real time and prior to the patient receiving such medication;

24
25 Advocate that the electronic record management program at the pharmacy filling the relevant
26 prescription, contemporaneously as it enters the filling of the prescription by the pharmacist,
27 likewise be required to automatically query the state PDMP as a secondary mechanism to
28 prevent inappropriate prescribing, forgery, duplication and/or too great a frequency of use of
29 the involved controlled medication;

30
31 Work with ACLM and other concerned societies to urge Congress to timely enact and
32 implement such a statutory scheme supported by a workable and concise regulatory
33 framework, chiefly concentrating on the interfacing of all applicable electronic health record
34 and pharmaceutical dispensing systems with every individual state's PDMP, thereafter
35 designating a timeframe wherein all treating providers and dispensing pharmacists would be

1 required to perform such queries, in concert with the routine ordering of and filling of a
2 controlled substance to be used in the treatment of patients;

3
4 Advocate that oversight of the appropriate prescribing of and filling of prescriptions for
5 controlled substances remain with the involved individual federal and state criminal law
6 enforcement agencies, the involved state departments of health, or similar entities and the
7 involved relevant state provider and/or pharmacy licensure authorities; and

8
9 Advocate that statistics be maintained and reviewed on a periodic basis by state PDMP
10 personnel and relayed to state departments of health or agencies similarly situated so as to
11 identify and possibly treat those patients identified through this screening mechanism as
12 potential drug abusers and/or at risk of addiction.

13
14 Board of Trustees (BOT) Report 12-A-18 summarized work that the AMA has done in support of
15 ensuring accurate, reliable Prescription Drug Monitoring Programs (PDMPs) that support clinical
16 decision-making. It also addressed many of the complexities raised in the original resolution,
17 including evolution of PDMPs, and their integration with electronic health records (EHRs) and
18 electronic prescribing of controlled substances (EPCS).

19
20 After debate, the HOD referred BOT Report 12-A-18 back for consideration. While general
21 support existed for the recommendations contained in the report, the HOD asked for additional
22 information on the evolution of PDMPs. This report, therefore, updates and expands upon the
23 information in BOT Report 12-A-18 and presents amended policy recommendations.

24 25 DISCUSSION

26
27 More than 300 million queries of state PDMPs were made in 2017, more than doubling the 136
28 million queries in 2016, and five times the 61 million queries submitted in 2014.¹ Physician
29 adoption of EHRs also continues to grow. The Office of the National Coordinator for Health
30 Information Technology maintains that nearly 90 percent of office-based physicians are using
31 EHRs.²

32
33 A major goal of AMA advocacy and many others continues to be the integration of electronic
34 systems that can support efforts to address the opioid epidemic. To effectively support physician
35 and public health efforts to prevent opioid overdose deaths, the AMA has urged that electronic
36 systems be interoperable and integrated into medical practice workflows. As noted in BOT
37 Report 12-A-18, information exchanged with EHRs is not well incorporated into the physician's
38 workflow. Obtaining important information, including PDMP data, often requires multiple
39 "clicks," opening multiple windows, and the use of separate logins even before the physician
40 locates what he or she is looking for—and that situation must be repeated for each patient and
41 every prescription for a controlled substance. Effective PDMP and EHR integration means that the
42 workflow must achieve "functional interoperability," or the ability for systems to exchange,
43 incorporate and display data in a meaningful and contextual manner.

44
45 The Centers for Medicare & Medicaid Services highlighted this in a recent letter to state Medicaid
46 directors, noting that when integration occurs, it "removes the requirement for providers to log in to
47 a separate system, manage a separate log in, and disrupt their workflow to query the PDMP. Single
48 sign-on interoperability between EHR and PDMP such that PDMP results are displayed when the
49 EHR indicates a controlled substance is prescribed could be supported, as an example."³

1 Many consider the ideal practice to be a “one-click” solution with PDMP data and EPCS integrated
2 into physicians’ EHR systems. On one hand, many EHR vendors are pulled in too many directions
3 to focus on this need. Federal regulations require vendors to develop EHRs that meet
4 administrative requirements. To achieve the ideal for PDMP and EPCS integration, more must be
5 done to reduce the regulatory pressure on health IT development, allowing vendors the flexibility
6 to respond to physician and patient needs, rather than spending the bulk of their time complying
7 with administrative demands.

8
9 Yet, there have been reports of progress of successful PDMP-EHR integration. For example, the
10 University of North Carolina (UNC) Health Care at Chapel Hill, reported that efforts to integrate
11 its Epic EHR with the state PDMP have been positive. A news report from July found that “[i]n the
12 first two weeks, more than 540 UNC clinicians used the PDMP when treating some 2,950 patients,
13 which officials said has saved physicians about 119 hours already.”⁴ Oschner Health System in
14 New Orleans, Louisiana, also has used Epic to integrate the EHR with the state PDMP.⁵ Deaconess
15 Health, which operates several hospitals in Indiana, also has made strides to integrate EHRs with
16 the state PDMP. And there are many different options in the commercial market, although your
17 Board notes that a Google search of effective PDMP-EHR integration efforts results in dozens of
18 options.⁶

19
20 In addition to growing physician use of PDMPs, interstate interoperability has expanded
21 considerably. According to the National Association of Boards of Pharmacy, 44 states now can
22 securely share PDMP information across state lines.⁷ The effects of expanded PDMP use on patient
23 care are mostly unknown; physicians and other health care professionals are not the only ones
24 interested in using the PDMP data.

25
26 As noted above, PDMP use among physicians and other health care professionals has significantly
27 increased in recent years; however, opioid-related mortality continues to increase, driven
28 principally by heroin, illicit fentanyl, and other synthetic derivatives. Moreover, as PDMP use
29 increases and opioid prescribing rates decrease, it is not clear that PDMPs are making a significant
30 impact on improving patients’ pain care. One review concluded that “[e]vidence that PDMP
31 implementation either increases or decreases nonfatal or fatal overdoses is largely insufficient, as is
32 evidence regarding positive associations between specific administrative features and successful
33 programs. Some evidence showed unintended consequences. Research is needed to identify a set of
34 “best practices” and complementary initiatives to address these consequences.”⁸

35
36 There may also be a need for additional clarity on how PDMP data may be used by non-health care
37 professionals, including health insurance companies, pharmacy benefit management companies
38 (PBMs), and law enforcement. For example, earlier this year, the U.S. Department of Justice and
39 48 attorneys general reached an agreement to share data. According to the news release, “Drug
40 Enforcement Agency DEA will provide the Attorneys General with that data, and the states will
41 provide their own information, often from prescription drug monitoring programs (PDMPs) to
42 DEA. Under the agreement, both state and federal law enforcement will have more information at
43 their disposal to find the tell-tale signs of crime.” It is not clear what these “tell-tale signs” might
44 be.

45
46 Progress has been considerably slower in achieving EPCS uptake,⁹ largely due to outdated
47 regulations from the DEA. The combination of personal identification numbers (PINs), passwords,
48 and biometrics required to meet DEA standards for “two-factor authentication” increase EPCS
49 security but add to workflow disruptions and increase costs. DEA, EPCS requirements include
50 onerous limits on use of biometric devices, which must comply with federal standards that set an
51 unnecessarily high bar and prevent use of user-friendly consumer electronics already found in

1 physicians' offices for two-factor authentication. The biometric fingerprint scanners found on these
2 consumer devices, i.e., smart phone, tables, and laptop computers, are used for secure access to
3 other sensitive information, like banking and medical records, but typically do not comport with
4 rigid rules for EPCS.

5
6 The AMA views EPCS as important to support high-quality patient care. Physicians commonly
7 report that they are frustrated that they can e-prescribe non-controlled substance medications but
8 must still use written prescriptions for controlled substances. More than 70 percent of physicians
9 are e-prescribing non-controlled drugs but only 20 percent used EPCS. One reason for this is due to
10 the fact that not all EHR vendors understand or can satisfy EPCS requirements—state EPCS
11 mandates have increased uptake, but implementation has been delayed due to questions about
12 system certification, cost to providers, and patient concerns, i.e., transferring prescriptions between
13 pharmacies. Moreover, EHR vendor processes for EPCS do not always align well with normal
14 e-prescribing workflows—often physicians must start new computer programs and windows each
15 time they use EPCS. Cumbersome workflows and applications that do not take physician needs
16 into account impede EPCS uptake. Finally, although EPCS reduces prescription fraud and
17 diversion, it is less clear how it affects valid prescriptions for opioid analgesics. For example, does
18 the prescriber using EPCS put in a dose and duration or are numbers suggested by the EPCS
19 system and, if so, how are these amounts derived? These are among the questions the AMA has
20 been asking from vendors and physicians.

21
22 To help resolve other barriers, the AMA and the President's Commission on Combating Drug
23 Addiction and the Opioid Crisis have recommended the DEA modify EPCS regulations in order to
24 reduce barriers to EPCS adoption. The AMA asked DEA to reexamine the scope of technology that
25 is compliant with EPCS requirements and allow use of lower-cost, high-performing biometric
26 devices in two-factor authentication. The AMA also believes that there must be further study to
27 evaluate the variations in how EPCS systems handle initial dosing, i.e., are opioid doses or
28 durations auto-populated in EPCS systems and, if so, are the amounts appropriate.

29
30 A final point is that the AMA has made clear to the DEA that its requirements for biometric
31 devices limit user-friendly consumer electronics already found in physicians' offices, such as
32 fingerprint readers on laptop computers and mobile phones, from being utilized for two-factor
33 authentication in EPCS. This and other rules contribute to cumbersome workflows and applications
34 which are an impediment to physician EPCS uptake. Encouraging EPCS uptake and
35 interoperability of PDMP databases and electronic health records would improve the integration of
36 controlled substance use data into practice workflows and clinical decision-making.

37
38 The AMA also continues its efforts in support of making PDMPs better clinical tools. The use of
39 PDMPs continues to increase in states regardless of mandates—tied mainly to quality of the PDMP
40 as a decision-support tool in those states without mandates. Important policies that have improved
41 PDMP workflow and data reliability include delegate access, data input by pharmacists within
42 24 hours, and states sharing PDMP information. PDMP usability continues to improve, but usage
43 in rural and other areas may be affected by lack of access to broadband and other technologies.
44 Consistent, long-term funding of state PDMPs is also a concern—most states depend on federal
45 grants for ongoing maintenance and improvements. The AMA also continues to try and identify
46 best practices in designing PDMPs to identify risk including: distinguishing between uncoordinated
47 care, misuse, and “doctor shopping,” identifying opportunities for referrals to specialized care;
48 providing reports to prescribers to better inform prescribing decisions; and conducting public
49 health surveillance activities.¹⁰

1 One best practice is PDMP and EHR integration, but, as previously discussed, that goal remains
2 largely elusive. It is not clear, for example, how many PDMPs are integrated into EHRs, which
3 makes identification of best practices challenging given the variety of EHR systems in use. Each
4 state PDMP may require a slightly different interface to connect to an EHR. With over 600
5 different EHRs on the market, the number of custom EHR/PDMP interfaces required can reach into
6 the thousands. Custom software development is time-consuming and expensive—with costs being
7 passed on to the physician. Without PDMP and EHR integration, physicians must use multiple
8 usernames and passwords to shuttle between different systems, often having to re-enter login
9 information if one system times out while they are using the other one. This results in increased
10 time to enter information, decreased satisfaction with the technology, and potentially less use of the
11 systems.

12
13 Furthermore, the AMA notes that one dominant PDMP developer is responsible for the PDMP
14 platforms of more than 40 states. PDMP quality and uptake has improved and it is clear that the
15 PDMP interface is moving toward greater integration through the use of more advanced tools
16 offered by the developer.¹¹ This development, along with the growing interstate interoperability has
17 led, anecdotally, to physicians receiving a greater number of alerts about potentially dangerous
18 drug combinations, multiple prescriber events, and other clinical issues. Yet, these advanced tools
19 are not without costs, and it is not clear how these tools may be affecting patient care. The PDMP
20 interface can help identify a patient's prescription history, but that is only one component of
21 effectively screening a patient for a potential substance use disorder or helping understand whether
22 a patient's pain is being effectively managed.

23
24 Similarly, while there are some positive examples with PDMP-EHR integration, EHRs are
25 generally not interoperable between different organizations, making coordination between primary
26 care physicians, pain medicine physicians, addiction medicine physicians and other providers much
27 more difficult. When PDMP and EHR integration does exist (e.g., Oregon's EDIE), the patient,
28 public health and cost utilization benefits are extremely positive.¹² This integration requires time
29 and broad, institutional support. For example, the state of Washington's integration project with the
30 state Health Information Exchange (HIE) began in 2012. As of August 2017, more than 90 percent
31 of emergency departments include PDMP data in the EHR using data through the HIE.¹³ The
32 state's major health systems still are working to accomplish this integration.

33
34 To help resolve some of these issues, the AMA advocates for consistent and sufficient
35 appropriations to support a state's ability to maintain and improve its PDMP, including broad state-
36 based grants to improve statewide HIEs and the ability to integrate HIE data into the EHR of
37 statewide emergency departments and other providers. The AMA also would support a U.S.
38 Government Accountability Office study on best practices for small and large physician practices
39 on using PDMPs to improve pain care as well as treatment for substance use disorders. This would
40 include identifying how PDMPs can distinguish uncoordinated care from misuse or "doctor
41 shopping" as well as help coordinate care for a patient with a substance use disorder or other
42 condition requiring specialty care. In addition, a need exists to evaluate the variations in state-based
43 PDMP technology and work with the health IT industry to discuss "common understanding" of
44 how each PDMP works—providing transparency for EHR vendors to facilitate development of
45 custom connections between their products and PDMP software. This could include funding for
46 programs that pilot test low-cost technologies to better integrate EHRs and PDMPs as well as
47 efforts to identify burdensome federal regulations that prevent EHRs from being designed and
48 developed to support objective clinical decision-making.

49
50 The AMA also has been engaged in the SMART project to help EHR systems work better for
51 physicians and patients. A key component of this effort is the development of a flexible

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.¹⁴ In addition, the Office of the National Coordinator for Health Information Technology has compiled multiple sources and pilot examples for PDMP and EHR integration.¹⁵ 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)

- 1 3. That our AMA support state-based pilot studies of best practices to integrate EHRs, EPCS and
2 PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such
3 integration from occurring. (New HOD Policy)

Fiscal Note: Less than \$500

REFERENCES

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- ² Office of the National Coordinator for Health Information Technology. 'Office-based Physician Electronic Health Record Adoption,' Health IT Quick-Stat #50. dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php. December 2016.
- ³ CMS letter to state Medicaid Directors, June 11, 2018. Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf>
- ⁴ <https://www.healthcareitnews.com/news/opioid-epidemic-unc-health-care-integrate-epic-ehr-states-pdmp>
- ⁵ <https://www.healthcareitnews.com/news/ochsner-integrates-opioid-monitoring-tool-its-epic-ehr>
- ⁶ Additional efforts in the commercial market to better integrate PDMP use into clinical workflow and integrate with EHRs include PMP Gateway from Appriss Health (<https://apprisshealth.com/solutions/pmp-gateway/>), web-based apps using SMART on FHIR protocols (<https://apps.smarthealthit.org/app/rxorbit-inworkflow-app>), a product from Allscripts (https://allscriptsstore.cloud.prod.iapps.com/applications/id-17010/LogiCoy_PDMP), to name a few.
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- ⁸ Fink DS, Schleimer JP, Sarvet A, Grover KK, Delcher C, Castillo-Carniglia A, et al. Association Between Prescription Drug Monitoring Programs and Nonfatal and Fatal Drug Overdoses: A Systematic Review. *Ann Intern Med*. 2018;168:783–790. doi: 10.7326/M17-3074. Available at <http://annals.org/aim/article-abstract/2680723/association-between-prescription-drug-monitoring-programs-nonfatal-fatal-drug-overdoses>
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- ¹⁰ PDMP TTAC. Prescription Drug Monitoring Training and Technical Center. Tracking PDMP Enhancement: The Best Practices. Available at http://www.pdmpassist.org/pdf/2016_Best_Practice_Checklist_Report_20170228.pdf
- ¹¹ Appriss Health Gateway explained at <https://apprisshealth.com/solutions/pmp-gateway/>
- ¹² ACEPNow. Emergency Department Information Exchange Can Help Coordinate Care for Highest Utilizers. Available at <http://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/2/>
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- ¹⁵ PDMPConnect. Office of the National Coordinator for Health Information Technology. Available at <https://www.healthit.gov/pdmp/PDMPConnect>

REPORT OF THE BOARD OF TRUSTEES

B of T Report 8-I-18

Subject: 340B Drug Discount Program
(Resolution 225-A-18 Resolve 3)

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

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

INTRODUCTION

At the 2018 Annual Meeting of the House of Delegates (HOD), the third resolve of Resolution 225-A-18 was referred for report back at the 2018 Interim Meeting. Resolution 225-A-18, sponsored by American Society of Clinical Oncology (ASCO), asked that our American Medical Association (AMA):

(3) support discontinuing the use of the Disproportionate Share Hospital (DSH) adjustment as a determining measure for 340B program eligibility;

The reference committee heard mixed testimony on this resolve. Testimony was offered that additional research and analysis is needed to assess how to identify the DSH hospitals that should not benefit from 340B program rebates and those that should. The reference committee recommended adopting Resolves 1, 2, and 4, and referral of Resolve 3 for a report back at the 2018 Interim Meeting.

AMA POLICY

Our AMA has an extensive policy that supports increased pharmaceutical drug and biological affordability and policies to ensure patient access to medically necessary prescription medication. However, our AMA does not have specific policy concerning the 340B program other than the HOD adopted resolves of Resolution 225-A-18 (Policy H-110.985, “340B Drug Discount Program”). There is a policy related to rebates which provides that our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. (Policy H-110.987, “Pharmaceutical Cost”). Thus, there is support for rebate programs to the extent such programs benefit underinsured patients and patients living on low-incomes. Consistent with the foregoing, AMA policy provides support for the subsidization of prescription drugs for Medicare patients based on means testing (Policy H-330.902, “Subsidizing Prescription Drugs for Elderly Patients”). However, AMA policy also includes support for economic assistance, including coupons (and other discounts), for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured (Policy H-125.977, “Non-Formulary Medication and the Medicare Part D Coverage Gap”).

1 BACKGROUND

2
3 The 340B program, which is administered by the U.S. Department of Health and Human Services’
4 (HHS) Health Resources and Services Administration (HRSA), requires pharmaceutical
5 manufacturers to sell outpatient prescription medication at a discount to covered entities. Congress
6 established the 340B program in order to produce savings for certain safety-net health care
7 providers by allowing them to purchase outpatient drugs at these discounted prices.¹ The U.S.
8 House of Representatives’ report, accompanying the original legislation, stated that these savings
9 would “enable [participating] entities to stretch scarce Federal resources as far as possible, reaching
10 more eligible patients and providing more comprehensive services.”² Pharmaceutical
11 manufacturers are required to enter into an agreement, called a pharmaceutical pricing agreement
12 (PPA), with the HHS Secretary. Under the PPA, the manufacturer agrees to provide front-end
13 discounts on covered outpatient prescription medication purchased by “covered entities.”
14

15 The 340B program definition of “covered entity” includes six categories of hospitals: (1)
16 disproportionate share hospitals (DSHs); (2) children’s hospitals; (3) cancer hospitals exempt from
17 the Medicare prospective payment system; (4) sole community hospitals; (5) rural referral centers;
18 and (6) critical access hospitals (CAHs).³ In addition, to qualify hospitals must be (1) owned or
19 operated by state or local government, (2) a public or private non-profit corporation which is
20 formally granted governmental powers by state or local government, or (3) a private non-profit
21 organization that has a contract with a state or local government to provide care to low-income
22 individuals who do not qualify for Medicaid or Medicare.⁴ Also, hospitals must meet payer-mix
23 criteria related to the Medicare DSH program with the exception of CAHs.⁵ There are also 11
24 categories of non-hospital covered entities that are eligible based on receiving federal funding that
25 include: federally qualified health centers (FQHCs); FQHC “look-alikes;” state-operated AIDS
26 drug assistance programs; Ryan White Comprehensive AIDS Resources Emergency Act clinics
27 and programs; tuberculosis, black lung, family planning, and sexually transmitted disease clinics;
28 hemophilia treatment centers; Title X public housing primary care clinics; homeless clinics; urban
29 Indian clinics; and Native Hawaiian health centers.⁶ Covered entities may provide drugs purchased
30 through the 340B program to all eligible patients, regardless of a patient’s payer status and whether
31 the drug is intended for self-administration or administration by a clinician. Discounts have been
32 estimated to range from 20-50 percent of the drug’s cost.⁷
33

34 DISCUSSION

35
36 Affordability and access to prescription medication is an area of increased focus by Congress and
37 the Trump Administration. In the past year the 340B program has become the subject of significant
38 scrutiny. A central question posed by a number of stakeholders: do the rapidly increasing number
39 of DSH hospitals eligible for the 340B program discounts provide low-income patients the benefit
40 of the prescription drug rebates that they receive? (Other aspects of the 340B program, addressed
41 by the newly adopted AMA policy concerning the 340B program, have also been flagged including
42 manufacturer and covered entity noncompliance with 340B program requirements and insufficient
43 federal agency authority and resources to provide appropriate oversight.)
44

45 The Affordable Care Act increased the size and scope of the 340B program by expanding
46 eligibility to more types of hospitals, such as critical access hospitals and sole community
47 hospitals, and expanded Medicaid eligibility. As a result of the latter, the number of hospitals
48 qualifying as DSH hospitals increased as DSH designation is calculated based on a formula that
49 utilizes the number of Medicaid covered patients that a hospital serves. The number of participating
50 unique covered entities has grown from 3,200 in 2011 to 12,722 in October 2017.⁸ The number of
51 hospitals has grown significantly, from 591 in 2005 to 2,479 as of October 2017.⁹

1 There have also been a number of unintended consequences of the 340B program. A 2015 Avalere
 2 study found that hospitals participating in the 340B program were more likely than non-340B
 3 hospitals to acquire independent physician practices.¹⁰ These acquisitions create financial windfalls
 4 for hospitals due to the 340B program yet do not necessarily improve affordability for patients.
 5 Patient costs and resultant co-pays/co-insurance and deductibles for care in a hospital outpatient
 6 department (HOPDs) can be higher than those in physician offices.¹¹ (In those instances, patient
 7 care in HOPDs is more costly for health insurers too.) Furthermore, some 340B eligible hospitals
 8 may have commercial contracts that pay substantially more than the Medicare rate for drugs,¹² so
 9 the profit margin can be multiples of the cost of the drug. Patients may face a 20 percent
 10 coinsurance on this higher amount. Yet, hospitals eligible for the 340B program obtain drugs at a
 11 substantial discount. The 340B program does not require that the hospital pass the savings to
 12 uninsured or underinsured low-income patients. To the extent that the hospital does not pass along
 13 the savings, the combined payment by insurer and patient provides profit for the 340B hospital; the
 14 additional volume generated when 340B hospitals acquire independent physician practices results
 15 in even greater profits. There are also reports that hospital systems have acquired 340B program
 16 eligible hospitals in order to purchase drugs for their suburban clinics utilizing the discounts even
 17 though such clinics do not serve uninsured or underinsured low-income patients.

18
 19 There have been several congressional hearings on the 340B program convened by the U.S.
 20 Senate's Health, Education, Labor, and Pension (HELP) Committee as well as the U.S. House of
 21 Representatives' Energy and Commerce (E&C) Committee. Testimony offered by the U.S.
 22 Government Accountability Office (GAO),¹³ the HHS Office of the Inspector General (OIG),¹⁴ and
 23 other witnesses included concerns with the 340B program's: (1) inadequate "patient" definition;
 24 (2) eligibility criteria for covered entity; (3) oversight of covered entities and manufacturers; and
 25 (4) oversight of the use of contract pharmacies. The lack of program data to assess the extent to
 26 which 340B program covered entities are ensuring low-income patients benefit from the rebates
 27 and the savings has particularly troubled policymakers and other stakeholders.

28
 29 In addition to the hearings, over 17 federal bills have been introduced concerning the 340B
 30 program in this Congress. A number of the bills would mandate reporting on care provided to low-
 31 income individuals and would impose new eligibility requirements for certain categories of
 32 covered entities. For example, in December 2017, Representative Larry Buschon (R-IN) introduced
 33 H.R. 4710, Protecting Access for Underserved and Safety-net Entities Act (340B PAUSE Act). The
 34 bill would impose a moratorium on registration for certain new 340B program hospitals and
 35 associated sites. H.R. 4710 would also mandate data collection by covered entities including the
 36 number and percentage of insured (by insurer) and uninsured individuals who are dispensed or
 37 administered 340B program discounted drugs. In January 2018, Senator Bill Cassidy (R-LA)
 38 introduced S. 2312, Helping Ensure Low-income Patients have Access to Care and Treatment Act
 39 (HELP Act). The bill would impose a registration moratorium on new non-rural 340B program
 40 covered entities and associated sites as well as new eligibility requirements for covered entities. It
 41 would also require reports on the level of charity care provided by covered entities. Similarly, in
 42 April 2018, Representative Earl Carter (R-GA) introduced H.R. 5598, 340B Optimization Act. The
 43 bill would amend the Public Health Service Act to require certain disproportionate share hospital
 44 covered entities under the 340B drug discount program submit to HHS reports on low-income
 45 utilization rates of outpatient hospital services furnished by such entities.

46
 47 In order to address the lack of data available directly from 340B program hospital covered entities
 48 or HRSA vis-à-vis the benefit to low-income patients, the House E&C Committee Chairman Greg
 49 Walden (R-OR) and health subcommittee Chairman Michael Burgess (R-TX) requested a report on
 50 the topic from the GAO. On June 18, 2018, the GAO issued the report, Drug Discount Program:

Characteristics of Hospitals Participating and Not Participating in the 340B Program. The report found that:

[i]n 2016 ... the median amount of charity care provided by all 340B hospitals ... was similar to the median amount provided by all non-340B hospitals, and the median amount of uncompensated care provided by these 340B hospitals was higher than that provided by their non-340B counterparts. But again, the differences between the 340B and non-340B hospitals varied across the different hospital types. For example, while the median amount of uncompensated care provided by 340B general acute care hospitals (340B DSH) was higher than that of their non-340B counterparts, the median amount provided by 340B CAHs was lower than that of non-340B CAHs.

While the report provides additional needed analysis and data, more information is needed concerning the program's implementation and benefit to low-income patients. To ensure the 340B program covered entity criteria aligns with the goal of ensuring low-income patients are able to access affordable treatments, at least one national medical specialty society has recommended that Congress establish new metrics that such entities must meet that are objective, universal, verifiable and align program eligibility with the care provided by the covered entity to indigent and underserved individuals. Consistent with the foregoing, alternative eligibility measures could be calculated by analyzing the amount of charity care provided by hospitals in the outpatient setting. Ultimately, eligibility should be designed to qualify entities based on the amount of care delivered to underserved populations in outpatient settings. This would dovetail with new AMA policy to work with policymakers to establish 340B program eligibility for all physician practices demonstrating a commitment to serving low-income and underserved patients, new covered entity criteria should promote participation by institutions and practices of all sizes in all settings. To advance this goal, ASCO has convened an expert workgroup to develop recommendations for a revised eligibility formula in order to appropriately capture the level of outpatient charity care provided by hospitals, as well as standalone community practices. ASCO will provide policymakers and other stakeholders with the recommendations during the current congressional session.

CONCLUSION

The significant growth of the 340B program, particularly among DSH hospitals, should align with newly adopted HOD policy concerning 340B program and related AMA policies. Specifically, the program should promote access to affordable prescription drugs by low-income patients receiving care from 340B program covered entities. In addition, our AMA should engage with national medical specialty societies to leverage expertise and align recommendations to federal policymakers.

RECOMMENDATIONS

In light of these considerations, your Board of Trustees recommends that the following recommendations be adopted in lieu of the third resolve Resolution 225-A-18 and the remainder of this report be filed:

1. That our American Medical Association support a revised 340B drug discount program covered entity eligibility formula, which appropriately captures the level of outpatient charity care provided by hospitals, as well as standalone community practices. (New HOD Policy)

- 1 2. Our AMA will confer with national medical specialty societies on providing policymakers with
2 specific recommended covered entity criteria for the 340B drug discount program. (Directive
3 to Take Action)

Fiscal Note: Less than \$5000

REFERENCES

¹ Section 340B of the Public Health Service Act, codified at 42 U.S.C. § 256b.

² H.R. Rept. No. 102-384 (Part 2), at 12 (1992) (Conf. Rept.).

³ 42 U.S.C. § 256b(a)(4)(A)–(K)

⁴ Id.

⁵ Id.

⁶ Id.

⁷ Statement of Debra A. Draper Director, Health Care, GAO, July 18, 2017, U.S. House of Representatives, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce hearing on Drug Discount Program, Updated on Agency Efforts to Improve 340B Program Oversight, Available from <https://www.gao.gov/assets/690/685903.pdf>

⁸ Review of the 340B Drug Pricing Program, U.S. House of Representatives Energy and Commerce Committee. Available from: https://energycommerce.house.gov/wp-content/uploads/2018/01/20180110Review_of_the_340B_Drug_Pricing_Program.pdf

⁹ Id.

¹⁰ Hospital Acquisitions of Physician Practices and the 340B Program, June 2015, Available from <http://340breform.org/userfiles/Avalere%20Acquisition.pdf>; and, National Patient Advocate Foundation’s Response to Additional Questions for the Record Relating to the Hearing Entitled “Examining Reforms to Improve the Medicare Part B Drug Program for Seniors” July 2013, Available from <https://docs.house.gov/meetings/IF/IF14/20130628/101055/HHRG-113-IF14-Wstate-Davenport-EnnisN-20130628-U4.pdf>

¹¹ An Avalere report on Cost of Cancer Care stated that its “risk-adjusted results suggest that treatment for patients receiving chemotherapy in a HOPD costs on average 24 percent more than treatment received in a physician’s office.” Available from <http://www.communityoncology.org/pdfs/avalere-cost-of-cancer-care-study.pdf>

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¹³ Statement of Debra A. Draper, Director, Health Care, GAO, May 15, 2018, U.S. Senate Committee on Health, Education, Labor, and Pensions hearing on Examining Oversight Reports on the 340B Drug Price Program.

¹⁴ Testimony of Ann Maxwell, Assistant Inspector General for Evaluation and Inspections, OIG HHS, May 15, 2018, U.S. Senate Committee on Health, Education, Labor, and Pensions hearing on Examining Oversight Reports on the 340B Drug Price Program.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-I-18

Subject: Violence Prevention
(Resolution 419-A-18, Resolves 1 and 3)

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

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 INTRODUCTION

2
3 Resolution 419-A-18, "Violence Prevention," was introduced by the Washington Delegation. The
4 first and third Resolves, which were referred by the House of Delegates, asked:

5
6 That our American Medical Association (1) advocate that a valid permit be required before the
7 sale of all rapidly-firing semi-automatic firearms and (3) study options for improving the
8 mental health reporting systems and patient privacy laws at both the state and federal levels
9 and how those can be modified to allow greater information sharing between state and federal
10 government, law enforcement, schools and mental health professionals to identify, track and
11 share information about mentally ill persons with high risk of violence and either report to law
12 enforcement and/or the National Instant Criminal Background Check System, with appropriate
13 protections.

14
15 Accordingly, this report addresses both firearm licensing and mental health reporting
16 requirements.

18 CURRENT AMA POLICY

19
20 As one of the main causes of intentional and unintentional injuries and deaths, the American
21 Medical Association (AMA) recognizes that firearm-related violence is a serious public health
22 crisis in the United States. The AMA has extensive policy on firearm safety and violence
23 prevention. Relevant to this report is existing policy that supports requiring the licensing of firearm
24 owners, including completion of a required safety course and registration of all firearms. The AMA
25 also supports a waiting period and background check for all firearm purchasers.

26
27 AMA also supports (1) the establishment of laws allowing family members, intimate partners,
28 household members, and law enforcement personnel to petition a court for the removal of a firearm
29 when there is a high or imminent risk for violence; (2) requiring states to have protocols or
30 processes in place for requiring the removal of firearms by prohibited persons; (3) requiring gun
31 violence restraining orders to be entered into the National Instant Criminal Background Check
32 System; and (4) efforts to ensure the public is aware of the existence of laws that allow for the
33 removal of firearms from high-risk individuals.

BACKGROUND

Council on Science and Public Health Report 4-A-18, “The Physician’s Role in Firearm Safety,” reviewed the epidemiology of firearm morbidity and mortality, identified barriers to physician counseling, discussed the 11th U.S. Circuit Court of Appeals decision, which held that Florida’s Firearm Owners’ Privacy Act violated the First Amendment, explained that there are no state or federal laws that prohibit physicians from counseling patients on firearm safety, outlined the risk factors for firearm injuries, and identified policies that grant the authority to remove firearms from high-risk individuals who already possess them. Because these issues were recently addressed, they are not considered in this report. This report focuses on the issues of licensing of firearm purchasers and mental health reporting.

The National Instant Criminal Background Check System (NICS)

The Brady Handgun Violence Prevention Act of 1993 required the establishment of a computerized system to facilitate background checks on individuals seeking to acquire firearms from federally licensed firearms dealers. The NICS was activated in 1998 and is administered by the Federal Bureau of Investigation (FBI). In 2010, federal and state agencies conducted 10.4 million background checks and more than 150,000 purchases were denied when purchasers were identified as prohibited persons.¹ However, records in the NICS are provided voluntarily by state, local, tribal, and federal agencies. Inconsistencies in states’ reporting of disqualifying records to the NICS, as well as loopholes (i.e., unlicensed dealers) in the requirements for background checks prior to a firearm purchase, contribute to the lack of success in consistently identifying individuals who are disqualified from possessing firearms.

Prohibited Persons and Mental Health

The federal Gun Control Act (GCA) of 1968 makes it unlawful for certain categories of persons to ship, transport, receive, or possess firearms or ammunition. Those categories include, but are not limited to individuals convicted of a felony; unlawful users or those with addiction involving any controlled substance; individuals adjudicated as a “mental defective” or under an order of civil commitment; individuals subject to a court order restraining them from harassing, stalking, or threatening an intimate partner or child of the intimate partner; or persons who have been convicted of a misdemeanor crime of domestic violence. “Adjudicated as a mental defective” is further defined as:

A determination by a court, board, commission, or other lawful authority that a person, as a result of marked subnormal intelligence, or mental illness, incompetency, condition, or disease: (1) Is a danger to himself or to others; or (2) Lacks the capacity to manage his own affairs. The term shall include – (1) a finding of insanity by a court in a criminal case, and (2) those persons found incompetent to stand trial or found not guilty by lack of mental responsibility (under the Uniform Code of Military Justice).²

Furthermore, “committed to a mental institution” is defined as:

A formal commitment of a person to a mental institution by a court, board, commission, or other lawful authority. The term includes a commitment to a mental institution involuntarily. The term includes commitment for mental defectiveness or mental illness. It also includes commitments for other reasons, such as for drug use. The term does not include a person in a mental institution for observation or a voluntary admission to a mental institution.³

1 It is important to note that a diagnosis of, or treatment for, mental illness does not alone qualify an
2 individual for reporting to the NICS.^{4, 5} Existing federal criteria for firearm-disqualifying mental
3 health records are not perfect. They have been criticized for being both over-inclusive and under-
4 inclusive.⁶ It is the American Psychiatric Association's position that:

5
6 Reasonable restrictions on gun access are appropriate, but such restrictions should not be based
7 solely on a diagnosis of mental disorder. Diagnostic categories vary widely in the kinds of
8 symptoms, impairments, and disabilities found in affected individuals. Even within a given
9 diagnosis, there is considerable heterogeneity of symptoms and impairments.⁷

10
11 Furthermore, individuals with mental illness, when appropriately treated, do not pose an increased
12 risk of violence compared with the general population.⁸ However, mental illness is strongly
13 associated with suicide, which represents nearly 60 percent of firearm-related deaths in the United
14 States.

15 16 DISCUSSION

17 18 *State Licensing Requirements*

19
20 Federal law does not require the licensing of firearm purchasers or owners. A number of states
21 have enacted licensing requirements to help prevent prohibited individuals from purchasing
22 firearms. Different types of firearm licensing laws exist in states. Permits-to-purchase (PTP)
23 licensing systems require prospective firearm purchasers to have direct contact with law
24 enforcement or judicial authorities that review the purchase application and verify the passage of a
25 background check.⁹ While similar to PTP laws, license to own firearm laws differ in that the
26 license must remain valid for as long as the person owns the firearm. Firearm safety certificates
27 require completion of a required safety training course as a part of the firearm licensing process in
28 addition to the passage of a background check. Firearm registration laws require individuals to
29 record their ownership of a firearm with a designated law enforcement agency.

30
31 PTP laws, which have been enacted in 10 states and the District of Columbia, are the most common
32 type of firearm licensing laws.¹⁰ In these jurisdictions, both licensed and unlicensed dealers can
33 only sell firearms to individuals with a current PTP license, closing the loophole that exists under
34 federal law. While the licensing requirements vary by state, they generally require an individual to
35 fill out a license or permit application form, submit the form in-person to the licensing authority,
36 and pay the required fees. A background check through the NICS is usually required. Some states
37 also require fingerprints to be taken as a part of the application process. In some jurisdictions
38 (Massachusetts, New York and New Jersey), law enforcement agencies have discretion in denying
39 a permit. If approved, the permit or license is issued. State licensing laws usually apply to specific
40 types of firearms (i.e., handguns or long guns and rifles).

41
42 States with PTP laws tend to have lower firearm-related death rates than states without these laws
43 after controlling for demographic, economic and other differences across states.¹¹ Evidence
44 suggests that state laws leading to tighter regulation of sale and possession of firearms, including
45 PTP laws, reduce the availability of in-state guns involved in crimes and traced by law
46 enforcement.¹² Furthermore, criminals who used firearms in places with PTP laws typically
47 acquired them from states with weaker laws.¹³ PTP laws also are associated with reductions in
48 firearm homicide and suicide rates. Connecticut's PTP law was associated with a 40 percent
49 reduction in firearm homicide rates during the first 10 years the law was in place while there was
50 no evidence for a reduction in non-firearm homicides.¹⁴ Missouri's firearm-related homicide rate
51 increased abruptly after the state repealed its PTP handgun licensing law in 2007. The state saw a

25 percent higher rate in the first three years post repeal than during the prior nine years.¹⁵ A study conducted in large urban counties found that PTP laws were associated with a 14 percent reduction in firearm homicides.¹⁶ PTP law enactment was associated with protective effects against firearm suicides in Connecticut, and PTP repeal in Missouri was associated with increased risk of firearm suicides.¹⁷

Mental Health Reporting

In 2007, the NICS Improvement Amendments Act (NIAA) authorized the Attorney General to provide grants to states to improve electronic access to records and incentivize states to turn over records of persons prohibited from possessing firearms.¹⁸ The NIAA created the NICS Act Record Improvement Program (NARIP), which provides funding to states to ensure that the appropriate mental health records are included in the NICS. In November of 2011, a report by Mayors Against Illegal Guns found that for complex legal and logistical reasons, records of serious mental health and substance use problems that disqualify people from firearm ownership have been difficult to capture in NICS.¹⁹ In 2012, the Government Accountability Office examined states' progress in reporting mental health records to the NICS. They found that from 2004 to 2011, the total number of mental health records that states made available to the NICS increased by 800 percent – from 126,000 to 1.2 million records.²⁰ However, the increase largely reflected the efforts of 12 states. A variety of technological, coordination, and legal (i.e., privacy) challenges limit states' ability to report mental health records.²¹

Technological challenges are relevant to mental health reporting because the records originate from multiple sources within a state (i.e., courts, private hospitals, state mental health agencies) and are not captured by a single agency.²² In terms of legal challenges, some states indicated that the lack of explicit state-level authority to share mental health records with NICS was an impediment.²³ Coordination challenges involved getting hospitals and departments of mental health to collaborate with law enforcement, who make the majority of records available to NICS.²⁴ Non-criminal justice entities may not be aware of NICS reporting requirements, or, if they are aware, may be unfamiliar with how to report.

Relationship to NARIP Funding. NARIP funding has been provided to states to address these barriers. In order to receive NARIP funding, states are required to have a "relief from disabilities statute" whereby firearm purchasing rights can be restored to a person who had them removed because of a mental health adjudication or involuntary commitment. Information on the level of funding by state from FY 2009-2017, as well as promising practices for improved record reporting to the NICS, are available on the Bureau of Justice Statistics website.²⁵ As of July 2015, there were 3.8 million state-submitted mental health records in the NICS.²⁶ Forty-three states have enacted laws that require (32) or authorize (11) the reporting of mental health records to NICS. The largest increase in reported mental health data from 2008 to 2015 occurred in states with a reporting requirement.²⁷ Twenty of the 26 states with the largest increase in mental health data also received NARIP funding.

HIPAA Considerations. In 2013 there was considerable focus on whether the Health Insurance Portability and Accountability Act (HIPAA) or state privacy laws were an obstacle to the submission of mental health records to NICS.²⁸ On January 4, 2016, the U.S. Department of Health and Human Services modified HIPAA to expressly permit certain covered entities to disclose to the NICS the identities of those individuals who, for mental health reasons, are prohibited by federal law from having a firearm.²⁹ The final rule noted that creating a limited express permission in the HIPAA Privacy Rule to use or disclose certain information relevant to the federal mental health prohibitor for NICS purposes was necessary to address barriers related to HIPAA, and to ensure

1 that relevant information can be reported for this important public safety purpose. The rule
2 specifically prohibits the disclosure of diagnostic or clinical information from medical records or
3 other sources, and any mental health information beyond the indication that the individual is
4 subject to the federal mental health prohibitor, and does not apply to most treating providers.³⁰

5
6 Education Records. The Family Educational Rights and Privacy Act (FERPA) is a Federal law that
7 protects the privacy of student education records. Due to the nature of mental health records
8 reported to the NICS, schools are not likely to be among the organizations reporting. However,
9 FERPA does have an exception that allows educational agencies and institutions to disclose
10 personally identifiable information from education records to appropriate parties in connection with
11 an emergency if knowledge of the information is necessary to protect the health and safety of the
12 student or other individuals.³¹ The information may be disclosed to any person whose knowledge
13 of the information is necessary to protect the health or safety of the student or other individuals.

14 15 CONCLUSION

16
17 The AMA House of Delegates adopted policy at A-18 to require the licensing of all firearm
18 owners. PTPs are a type of license, thus a separate policy requiring a permit prior to the sale of
19 rapidly-firing semi-automatic firearms is not necessary. This requirement is encompassed in the
20 existing licensing policy. However, amending the policy to clarify that permits are a type of license
21 would be helpful to avoid future confusion.

22
23 In terms of mental health reporting, several national reports have identified the technological,
24 coordination, and legal (i.e., privacy) challenges that limit states' ability to report mental health
25 records to the NICS. In recent years, progress has been made to increase the reporting of these
26 records through the enactment of state reporting requirements, federal grants to states to address
27 collaboration through state level task forces focused on NICS improvement, training to help
28 identify the records that should be reported, automated transfer of mental health data to the NICS,
29 and clarification of federal privacy laws. In addition, legislation was enacted by Congress as part of
30 the FY 2018 Omnibus Appropriations bill—the Fix NICS Act of 2017—that, among other
31 provisions, requires states to develop a plan to ensure maximum coordination and automation of
32 the reporting the NICS.³² The law also reauthorizes NARIP through FY 2022.³³ While existing
33 AMA policy supports a waiting period and background checks for all firearm purchases, AMA
34 policy does not currently address deficiencies in the current NICS system.

35
36 In addition to the NICS system, it is important to have policies in place that remove current access
37 to firearms rather than just preventing the purchase of new firearms by individuals who are at high
38 or imminent risk for harming themselves or others. The Council on Science and Public Health
39 report and recommendations on “The Physician’s Role in Firearm Safety,” at A-18 led to the
40 adoption of policy addressing the removal of firearms from high risk individuals, which includes
41 support for gun violence restraining orders. Since overlapping policy on gun violence restraining
42 was adopted and appended to Policy H-145.996, “Firearm Availability.” We recommend
43 streamlining AMA policy in this area and removing the reference to “red flag” laws.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of the first and third resolves of Resolution 419-A-18 and the remainder of the report be filed.

1. That Policy H-145.996, "Firearm Availability" be amended by addition and deletion to read as follows:

H-145.996 Firearm Availability

1. Our AMA: (a) Advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA ~~policy is to~~ supports requiring ~~require~~ the licensing/permitting of ~~owners of~~ firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports granting local law enforcement discretion over whether to issue concealed carry permits. ~~in the permitting process in such that local police chiefs are empowered to make permitting decisions regarding "concealed carry", by supporting "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and by supporting "red flag" laws for individuals who have demonstrated significant signs of potential violence.~~ In supporting local law enforcement, we also support as well the importance of "due process" so that decisions could be reversible by individuals can petition petitioning in court for their rights to be restored. (Modify Current HOD Policy)

2. That Policy H-145.972, "Firearms and High-Risk Individuals" be reaffirmed.

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. (Reaffirm HOD Policy)

3. That our American Medical Association: (1) encourages the enactment of state laws requiring the reporting of relevant mental health records, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of mental health records to NICS to improve the quality and timeliness of the data. (New HOD Policy)

Fiscal Note: Less than \$500.

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- ⁷ American Psychiatric Association. Position Statement on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services. Accessed March 19, 2018.
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- ¹⁷ Crifasi CK, Meyers JS, Vernick JS, et al. Effects of changes in permit-to-purchase handgun laws in Connecticut and Missouri on suicide rates. *Prev. Med. Preventive Medicine*. 2015;79: 43-49.
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³¹ 34 CFR 99.36

³² Public Law No: 115-141.

³³ Public Law No: 115-141.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(I-18)

Introduced by: Virginia, American Association of Clinical Urologists, Georgia

Subject: Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

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

5
6 Whereas, [HB 139](#) was successfully passed by the 2018 Virginia General Assembly and signed
7 into law by Governor Northam. This allows physicians who are waiting to be credentialed by a
8 health plan to see patients and retroactively receive payments if they are ultimately
9 credentialed; and

10
11 Whereas, Physicians awaiting credentialing could be reimbursed \$1000 per day during the
12 credentialing process (*Virginia Medical News* – Spring/Summer 2018); therefore be it

13
14 RESOLVED, That our American Medical Association develop model state legislation for
15 physicians being credentialed by a health plan to treat patients and retroactively receive
16 payments if they are ultimately credentialed. (Directive to Take Action)

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

Received: 08/28/18

RELEVANT AMA POLICY

Physician Privileges Application - Timely Review by Managed Care H-180.956

Our AMA policy is that: (1) final acceptance of residents who otherwise are approved by a health plan should be contingent upon the receipt of a letter from their program director stating that their training has been satisfactorily completed; (2) health plans which require board certification should allow the completing resident to be included in their plan after showing evidence of having completed the required training and of working towards fulfilling the requirements in the time frame established by their respective Board for completion of certification; and (3) Medicare, Medicaid, and managed care organizations should (a) make final physician credentialing determinations within 45 calendar days of receipt of a completed application; (b) grant provisional credentialing pending a final credentialing decision if the credentialing process exceeds 45 calendar days; and (c) retroactively compensate physicians for services rendered from the date of their credentialing.

Res. 708, A-01 Modified Sub. Res. 701, I-01 Reaffirmed: Res. 809, I-02 Reaffirmation A-05 Reaffirmation A-15 Reaffirmed: CME Rep. 1, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(I-18)

Introduced by: Pennsylvania

Subject: Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

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

3
4 Whereas, The Centers for Disease Control and Prevention in August 2018 reported a record
5 72,000 overdose deaths in 2017 (2); and

6
7 Whereas, Medications for opioid use disorder can facilitate recovery and prevent deaths (3);
8 and

9
10 Whereas, Great Britain, Canada and Australia have successfully made methadone available by
11 prescription, enhancing access to this valuable therapy (1); and

12
13 Whereas, Limited experience in the United States over a 10-year period has demonstrated the
14 success of such a primary care approach for treatment of opioid use disorder (1); and

15
16 Whereas, In 2001, there was a six-month randomized controlled trial that supported the success
17 of such a primary care based approach (4, 5); and

18
19 Whereas, Enhancing the opportunity for primary care practices to prescribe methadone might
20 increase the availability of such treatment in non-urban populations who lack access to
21 methadone clinics; and

22
23 Whereas, AMA Policy H-95.957 supports the concept of "...properly trained practicing
24 physicians as an extension of organized methadone maintenance programs in the management
25 of those patients whose needs for allied services are minimal...."; therefore be it

26
27 RESOLVED, That our American Medical Association identify and work to remove those
28 administrative and/or legal barriers that hamper the ability of primary care providers to prescribe
29 methadone, through all appropriate legislative and/or regulatory means possible (Directive to
30 Take Action); and be it further

31
32 RESOLVED, That our AMA, working with other federation stakeholders, identify the appropriate
33 educational tools that would support primary care physicians to provide ongoing methadone
34 treatment for appropriate patients. (Directive to Take Action)

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

Received: 09/21/18

References:

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RELEVANT AMA POLICY**Methadone Maintenance in Private Practice H-95.957**

Our AMA: (1) reaffirms its position that, "the use of properly trained practicing physicians as an extension of organized methadone maintenance programs in the management of those patients whose needs for allied services are minimal" (called "medical" maintenance) should be evaluated further; (2) supports the position that "medical" methadone maintenance may be an effective treatment for the subset of opioid dependent patients who have attained a degree of behavioral and social stability under standard treatment and thereby an effective measure in controlling the spread of infection with HIV and other blood-borne pathogens but further research is needed; (3) encourages additional research that includes consideration of the cost of "medical" methadone maintenance relative to the standard maintenance program (for example, the cost of additional office security and other requirements for the private office-based management of methadone patients) and relative to other methods to prevent the spread of blood-borne pathogens among intravenous drug users; (4) supports modification of federal and state laws and regulations to make newly approved anti-addiction medications available to those office-based physicians who are appropriately trained and qualified to treat opiate withdrawal and opiate dependence in accordance with documented clinical indications and consistent with sound medical practice guidelines and protocols; and (5) urges that guidelines and protocols for the use of newly approved anti-addiction medications be developed jointly by appropriate national medical specialty societies in association with relevant federal agencies and that continuing medical education courses on opiate addiction treatment be developed by these specialty societies to help designate those physicians who have the requisite training and qualifications to provide therapy within the broad context of comprehensive addiction treatment and management.

CSA Rep. 2 - I-94 Reaffirmed: CSA Rep. 12 and Append Res. 412, A-99 Reaffirmation I-00

Modified: CSAPH Rep. 1, A-10

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-18)

Introduced by: Resident and Fellow Section

Subject: Support for the Development and Distribution of HIPAA-Compliant
Communication Technologies

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law designed to protect a subset of identifiable information known as Protected Health Information (PHI) and in 2009 HIPAA was expanded and strengthened by the Health Information Technology for Economic and Clinical Health Act (HITECH Act); and

Whereas, The AMA has guidelines that expect all institutions to provide retirement benefits; and

Whereas, All technologies designed to be HIPAA-compliant must adhere to two rules: the 'Standards for Privacy of Individually Identifiable Health Information' known as the Privacy Rule, and the 'Security Standards for the Protection of Electronic Protected Health Information' known as the Security Rule¹; and

Whereas, Baseline cell phone security, text messaging and telecommunication technologies are lacking in necessary security measures to meet the standards for HIPAA-compliance^{2,3}; and

Whereas, There are an increasing number of HIPAA-compliant applications related to patient health and communication with several versions of developer's guides for HIPAA-compliance distributed online for several years; and

Whereas, Despite evidence from studies showing perceived improvement in provider communication with HIPAA-compliant text messaging applications, more than 50% of residents report routinely text messaging protected health information (PHI) in violation of HIPAA^{3,4}; therefore be it

RESOLVED, That our American Medical Association promote the development and use of Health Insurance Portability and Accountability Act of 1996 (HIPAA) -compliant technologies for text messaging, electronic mail and video conferencing. (New HOD Policy)

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

Received: 09/27/18

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3 <https://link.springer.com/article/10.1007/s10916-016-0489-2>

4 <http://onlinelibrary.wiley.com/doi/10.1002/jhm.2228/full>

RELEVANT AMA POLICY

Face-to-Face Encounter Rule D-330.914

1. Our AMA will: (A) work with the Centers for Medicare & Medicaid Services (CMS) and appropriate national medical specialty societies to ensure that physicians understand the alternative means of compliance with and payment policies associated with Medicare's face-to-face encounter policies, including those required for home health, hospice and durable medical equipment; (B) work with CMS to continue to educate home health agencies on the face-to-face documentation required as part of the certification of eligibility for Medicare home health services to ensure that the certification process is streamlined and minimizes paperwork burdens for practicing physicians; and (C) continue to monitor legislative and regulatory proposals to modify Medicare's face-to-face encounter policies and work to prevent any new unfunded mandatory administrative paperwork burdens for practicing physicians.

2. Our AMA will work with CMS to enable the use of HIPAA-compliant telemedicine and video monitoring services to satisfy the face-to-face requirement in certifying eligibility for Medicare home health services. (CMS Rep. 3, I-12; Appended: Res. 120, A-14; Reaffirmed in lieu of: Res. 109, A-17)

Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging D-478.970

Our AMA will develop patient-oriented educational materials about text messaging and other non-HIPAA-compliant electronic messaging communication between physicians, patients, and members of the health care team.

Citation: Res. 227, A-16; Modified: Speakers Rep., A-18

Guidelines for Patient-Physician Electronic Mail H-478.997

New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Furthermore, before using electronic mail or other electronic communication tools, physicians should consider Health Information Portability and Accountability Act (HIPAA) and other privacy requirements, as well as related AMA policy on privacy and confidentiality, including Policies H-315.978 and H-315.989. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient's care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.

(1) For those physicians who choose to utilize e-mail for selected patient and medical practice communications, the following guidelines be adopted.

Communication Guidelines:

- (a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
- (b) Inform patient about privacy issues.
- (c) Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.
- (d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of email communications with patients.
- (e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
- (f) Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
- (g) Request that patients put their name and patient identification number in the body of the message.
- (h) Configure automatic reply to acknowledge receipt of messages.
- (i) Send a new message to inform patient of completion of request.
- (j) Request that patients use autoreply feature to acknowledge reading clinicians message.
- (k) Develop archival and retrieval mechanisms.
- (l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
- (m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
- (n) Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
- (o) Explain to patients that their messages should be concise.

(p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.

(q) Remind patients when they do not adhere to the guidelines.

(r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

Medicolegal and Administrative Guidelines:

(a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:

(b) Terms in communication guidelines (stated above).

(c) Provide instructions for when and how to convert to phone calls and office visits.

(d) Describe security mechanisms in place.

(e) Hold harmless the health care institution for information loss due to technical failures.

(f) Waive encryption requirement, if any, at patient's insistence.

(g) Describe security mechanisms in place including:

(h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.

(i) Never forwarding patient-identifiable information to a third party without the patient's express permission.

(j) Never using patient's e-mail address in a marketing scheme.

(k) Not sharing professional e-mail accounts with family members.

(l) Not using unencrypted wireless communications with patient-identifiable information.

(m) Double-checking all "To" fields prior to sending messages.

(n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.

(o) Commit policy decisions to writing and electronic form.

(2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.

(3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate.

(4) The policies and procedures for e-mail be applied to text and electronic messaging using a secure communication platform, where appropriate. (BOT Rep. 2, A-00; Modified: CMS Rep. 4, A-01; Modified: BOT Rep. 24, A-02; Reaffirmed: CMS Rep. 4, A-12; Modified: BOT Rep. 11, A-17)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(I-18)

Introduced by: Resident and Fellow Section

Subject: Restriction on IMG Moonlighting

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, The Association of American Medical Colleges predicts a physician shortage of more than 100,000 doctors by the year 2030¹; and

Whereas, International Medical Graduates (IMGs) are more likely to practice in primary care specialties than US medical graduates²; and

Whereas, Foreign-born IMGs were more likely to practice in rural underserved areas than US born IMGs²; and

Whereas, The Educational Commission for Foreign Medical Graduates (ECFMG) sponsors approximately 10,000 J-1 visas annually; and

Whereas, The ECFMG prohibits physicians with a J-1 visa from moonlighting based on the US Code of Federal Regulations 22CFR62.16³, and subsequently prohibits physicians with J-1 visas privileges to bill for services rendered; and

Whereas, Providing physicians with a J-1 visa billing privileges and the ability to moonlight may improve the access to care in certain areas; therefore be it

RESOLVED, That our American Medical Association advocate for changes to federal legislation allowing physicians with a J-1 visa in fellowship training programs the ability to moonlight. (New HOD Policy)

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

Received: 09/27/18

RELEVANT AMA POLICY

Employment of Non-Certified IMGs H-255.970

Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure; and (2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs.
Citation: (Res. 309, A-03; Reaffirmed: CME Rep. 2, A-13)

References:

¹ Research Shows Shortage of More than 100,000 Doctors by 2030. Available at: <https://news.aamc.org/medical-education/article/new-aamc-research-reaffirms-looming-physician-short/>.

² International Medical Graduates and The Primary Care Workforce For Rural Underserved Areas. Available at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.22.2.255>.

³ Employment Outside of the Approved Training Program ("Moonlighting"). Available at <https://www.ecfm.org/evsp/evspemot.pdf>.

MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(I-18)

Introduced by: International Medical Graduates Section

Subject: Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, Our AMA has supported legalization of the Deferred Action for Early Childhood Arrival (DACA) children brought to this country illegally by their parents; and

Whereas, Our AMA has supported reducing the backlog of granting of green cards for permanent residency which sometimes has been delayed for several years. This delay leads to their children turning 21 years of age and thus becoming illegal; and

Whereas, There are thousands of children who arrived in this country with their parents legally, however once they turn 21 years of age they automatically become illegal. They are then called DALCA (Deferred Action for Legal Childhood Arrival); and

Whereas, There are 80,000-100,000 children that fall into this category; and

Whereas, Many of these DALCA children are in medical schools or have already graduated from U.S. medical schools, but are subject to deportation because they are considered illegals. Many of these DALCA children have matched in residency programs but have been held back due to their lack of proper legal status; and

Whereas, There is bipartisan support in Congress for these children which has not garnered media headlines; therefore be it

RESOLVED, That our American Medical Association support legalization of the Deferred Action for Legal Childhood Arrival (DALCA) (New HOD Policy); and be it further

RESOLVED, That our AMA work with the appropriate agencies to allow DALCA children to start and finish medical school and/or residency training until these DALCA children have officially become legal. (Directive to Take Action)

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

Received: 09/28/18

References:

"Consideration of Deferred Action for Childhood Arrivals (DALCA)"

"Deferred Action for Childhood Arrivals: Response to January 2018 Preliminary Injunction"

<https://www.uscis.gov/humanitarian/deferred-action-childhood-arrivals-response-january-2018-preliminary-injunction>

"Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children Memorandum," June 15, 2012, <https://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf>

RELEVANT AMA POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
 2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
 3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
 4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
 5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
 6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
- (Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18)

Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986

1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.
 2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.
- (Res. 305, A-15; Appended: Late Res. 1001, I-16)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-18)

Introduced by: Florida

Subject: Repealing Potential Penalties Associated with MIPS

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Reporting data under the Merit-based Incentive Payment System (MIPS) increases
2 the administrative burden on physicians and takes time away from patient care; and
3

4 Whereas, The maximum potential payment penalty under MIPS will incrementally increase to
5 9%; and
6

7 Whereas, Many physician practices that serve Medicare beneficiaries cannot sustain additional
8 reductions in their Medicare payments; and
9

10 Whereas, Small and medium-sized physician practices are likely to be disproportionately
11 impacted by penalties under MIPS; and
12

13 Whereas, Participation in pay-for-performance programs should not be compulsory; therefore
14 be it
15

16 RESOLVED, That our American Medical Association advocate to repeal all potential penalties
17 associated with the MIPS program. (Directive to Take Action)

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

Received: 09/27/18

RELEVANT AMA POLICY

Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program D-395.998

1. Our AMA will oppose the replacement of the Merit-Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently defined.
2. Our AMA will study the criticisms of the Merit-Based Incentive Payment System (MIPS) program as offered by proponents of the VVP to determine where improvement in the MIPS program needs to be made.
3. Our AMA will continue its advocacy efforts to improve the MIPS program, specifically requesting: (a) true EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures; (b) safe harbor protections for entities providing clinical data for use in the MIPS program; (c) continued infrastructure support for smaller practices that find participation particularly burdensome; (d) adequate recognition of and adjustments for socioeconomic and demographic factors that contribute to variation in patient outcomes as well as geographic variation; and (e) limiting public reporting of physician performance to those measures used for scoring in the MIPS program.
4. Our AMA will determine if population measures are appropriate and fair for measuring physician performance.

Citation: Res. 247, A-18

Reducing MIPS Reporting Burden D-395.999

Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physicians choosing) within the calendar year.

Citation: Res. 236, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(I-18)

Introduced by: Medical Student Section

Subject: Defense of Affirmative Action

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Affirmative action is a race-conscious recruitment policy designed to equalize access
2 to jobs and professions such as medicine and is based on the premise that relief from illegal
3 racial discrimination is not enough to remove the burden of second-class citizenship from
4 underrepresented minority groups;¹ and
5

6 Whereas, Affirmative action has been identified as a potent method for ameliorating racial
7 disparities and increasing diversity in public universities;^{2,3} and
8

9 Whereas, University enrollment is directly correlated with attaining higher social status;⁴ and
10

11 Whereas, Diversity in the student body fosters a greater understanding of patient populations
12 and preparation for medical care to an increasingly multicultural society;^{5,6} and
13

14 Whereas, Underrepresented minority physicians are more likely to practice in underserved
15 areas and tend to serve populations with higher percentages of medically indigent patients;⁷⁻⁹
16 and
17

18 Whereas, Affirmative action has shown to increase medical practice in underserved areas with
19 minority populations and providing better healthcare for various communities;¹⁰ and
20

21 Whereas, Several states that have instituted bans on affirmative action have experienced
22 subsequent decreases in college enrollment by minority students, completion of STEM degrees
23 by minority students, and representation of minority students among matriculating medical
24 school students;^{2,3,11,12} and
25

26 Whereas, In 1978, 2003, and 2016 the supreme court upheld affirmative action in the cases of
27 *Regents of the University of California v. Bakke*, *Grutter v. Bollinger*, and *Fisher v. The*
28 *University of Texas at Austin*, respectively, allowing race to be one of several factors in college
29 admission policy;¹³⁻¹⁵ and
30

31 Whereas, Although AMA policy establishes a significant precedent to support undergraduate
32 education as a means to produce medical school matriculants (H-60.917, H-350.979,
33 H-200.985), existing policy falls short of addressing the necessity of affirmative action as
34 mechanism for equality at the undergraduate level, which is necessary to bolster the pool of
35 minority students able to apply to a medical program; and
36

37 Whereas, The Department of Justice has announced the intent to investigate and potentially
38 sue institutions utilizing affirmative action, threatening the principles of racial equality in
39 education that our AMA supports;¹⁶ therefore be it

- 1 RESOLVED, That our American Medical Association oppose legislation that would undermine
2 institutions' ability to properly employ affirmative action to promote a diverse student population.
3 (New HOD Policy)

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

Received: 09/28/18

References:

1. Curtis, JL. Affirmative action in U.S. medical schools. *Affirmative Action in Medicine: Improving Health Care for Everyone*. Ann Arbor, MI: University of Michigan Press; 2003:13-34.
2. Porter, M, Clausen, E. *Fisher* ruling requires buy-in, assessment of diversity, affirmative action. *Enrollment Management Report*. 2016;20(10):1-8.
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4. Hinrichs, P. The Effects of Affirmative Action Bans on College Enrollment, Educational Attainment, and the Demographic Composition of Universities. *Review of Economics and Statistics*. 2012;94(3):712-722.
5. Lakhan SE. Diversification of U.S. medical schools via affirmative action implementation. *BMC Medical Education*. 2003;3(1).
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7. Kington, R, Tisnado, D, Carlisle, DM. Increasing racial and ethnic diversity among physicians: an intervention to address health disparities? *The Right Thing To Do, The Smart Thing To Do: Enhancing Diversity in the Health Professions*. Washington, DC: The National Academies Press; 2001:57-90.
8. Walker, KO, Moreno, G, Grumbach, K. The Association Among Specialty, Race, Ethnicity, and Practice Location Among California Physicians in Diverse Specialties. *J Natl Med Assoc*. 2012;104(0):46-52.
9. Marrast, LM, Zallman, L, Woolhandler, S. *et al*. Minority Physicians' Role in the Care of Underserved Patients: Diversifying the Physician Workforce May Be Key in Addressing Health Disparities. *JAMA Intern Med*. 2014;174(2):289-291.
10. Lakhan SE. Diversification of U.S. medical schools via affirmative action implementation. *BMC Medical Education*. 2003;3(1).
11. Hill, AJ. State Affirmative Action Bans and STEM Degree Completions. *Economics of Education Review*. 2017;57:31-40.
12. Garces, LM, Mickey-Pabello, D. Racial Diversity in the Medical Profession: The Impact of Affirmative Action Bans on Underrepresented Student of Color Matriculation in Medical Schools. *J Higher Educ*. 2015 Mar-Apr;86(2):264-294.
13. *Regents of University of California v. Bakke* 438 U.S. 265 (1978).
14. *Gratz v. Bollinger*; *Grutter v. Bollinger*. The Center for Individual Rights. <https://www.cir-usa.org/cases/gratz-v-bollinger-grutter-v-bollinger>. Accessed August 25, 2017.
15. *Fisher v. University of Texas at Austin et al*. 579 U.S. ____ (2016).
16. Savage, A. Justice Dept. to Take On Affirmative Action in College Admissions. *New York Times*. August 1st, 2017

RELEVANT AMA POLICY

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917

Our AMA: (1) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (2) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (3) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.

Citation: Res. 910, I-16

Equal Opportunity H-65.968

Our AMA: (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; (2) affirms the concept that equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender; (3) affirms the concept of equal rights for men and women; and (4) endorses the principle of equal opportunity of employment and practice in the medical field.

Citation: (CCB/CLRPD Rep. 4, A-13)

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.

- (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
- (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
- (4) Increasing the supply of minority health professionals.
- (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
- (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
- (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
- (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(I-18)

Introduced by: Nebraska, Georgia, West Virginia, Florida, Mississippi, South Carolina,
Arkansas, Oklahoma, New Jersey, Tennessee

Subject: Increasing Access to Broadband Internet to Reduce Health Disparities

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Our AMA recognizes that social determinants of health, including circumstances of
2 early life, social gradient, unemployment, and social exclusion, should be taught in medical
3 school (H-295.874) and built in to payment models (H-160.896); and
4

5 Whereas, Residents of rural areas in the United States tend to be older and sicker than their
6 urban counterparts with higher rates of poverty, less access to healthcare, and higher likelihood
7 of dying from 5 leading causes of death when compared to their urban counterparts; and
8

9 Whereas, 23 million Americans live in areas that do not have broadband internet access; and
10

11 Whereas, Broadband internet provides access to resources not only for health care but also for
12 economic growth and job opportunities, educational opportunities, and government services;
13 and
14

15 Whereas, Our AMA has a broad swath of policies which encourage the use of, and pay for,
16 telemedicine, which requires broadband internet; and
17

18 Whereas, The Federal Communications Commission Connect2Health Task Force is currently
19 exploring the intersections of health and technology in rural areas; therefore be it
20

21 RESOLVED, That our American Medical Association advocate for the expansion of broadband
22 connectivity to all rural areas of the United States. (New HOD Policy)

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

Received: 09/28/18

RELEVANT AMA POLICY

Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874

Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.

Citation: CME Rep. 11, A-06; Reaffirmation A-11; Modified in lieu of Res. 908, I-14; Reaffirmed in lieu of Res. 306, A-15; Reaffirmed: BOT Rep. 39, A-18

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896

Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.

Citation: BOT Rep. 39, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(I-18)

Introduced by: Women Physicians Section

Subject: Sexual Assault Education and Prevention in Public Schools

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

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 old¹; 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 sex²; 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 students²; 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 consent⁴⁻⁶; 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:

1. Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens MR. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2011.
2. Youth Risk Behavior Surveillance — United States, 2017. Available at <https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2017/ss6708.pdf>.
3. Culture of Silence: How a lack of consent education harms high school students. Available at <https://www.sjsreview.com/9257/news/how-a-lack-of-consent-education-harms-high-school-students/>.
4. An Act to amend and reenact § 22.1-207.1:1 of the Code of Virginia, relating to high school family life education curricula; elements of effective and evidence-based programs on consent. Available at <http://lis.virginia.gov/cgi-bin/legp604.exe?171+ful+CHAP0299>.
5. Teaching Consent: Could Oklahoma Lead a New Wave in Sex Education? Available at <https://www.rollingstone.com/politics/politics-news/teaching-consent-could-oklahoma-lead-a-new-wave-in-sex-education-629220/>.
6. Governor approves bills on marriage age, teaching of consent in schools. Available at <https://krcgtv.com/news/local/governor-approves-bills-on-marriage-age-teaching-of-consent-in-schools>.

RELEVANT AMA POLICY**Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968**

- (1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
- (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
- (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
- (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
- (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
- (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
- (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted

infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;

(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and

(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

Citation: CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16; Appended: Res. 401, A-16; Appended: Res. 414, A-18; Appended: Res. 428, A-18

Addressing Sexual Assault on College Campuses H-515.956

Our AMA: (1) supports universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting; (2) will work with relevant stakeholders to address the issues of rape, sexual abuse, and physical abuse on college campuses; and (2) will strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses.

Citation: Res. 402, A-16; Appended: Res. 424, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(I-18)

Introduced by: District of Columbia

Subject: Forced Organ Harvesting for Transplantation

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Ethical guidelines for transplantation are set forth by our AMA, the World Medical
2 Association and the World Health Organization; the medical profession has the responsibility to
3 protect the rights and interests of patients who need and seek transplant surgery, as well as to
4 protect the rights and interests of organ donors whose organs may have been procured in
5 unethical manner; and
6

7 Whereas, China is second only to the United States as the country that performs the largest
8 number of transplants and thus has a particular responsibility to act ethically and transparently
9 regarding organ transplants; and
10

11 Whereas, Systematic, state-sanctioned organ harvesting from executed prisoners and prisoners
12 of conscience in China has occurred with the knowledge of the Chinese government; and there
13 are also reports about forced organ harvesting from Uighurs, House Christians, Tibetans and
14 Falun Gong practitioners; and
15

16 Whereas, The U.S. Congress passed House Resolution 343 in 2016, calling for an end to
17 forced organ harvesting from Falun Gong prisoners of conscience in China; and the European
18 Parliament also passed Written Declaration 48 in 2016, calling for investigations and an end to
19 forced organ harvesting from Falun Gong prisoners of conscience in China; and
20

21 Whereas, Doctors Against Forced Organ Harvesting (DAFOH), a medical NGO that was
22 nominated twice for a Nobel Peace Prize, collected over 3 million signatures for a petition to the
23 U.N. High Commissioner for Human Rights, calling for an end to forced organ harvesting in
24 China; and
25

26 Whereas, Chinese transplant numbers have increased dramatically and transplant tourism has
27 become a lucrative source of income in China, leading to a rapid expansion of the transplant
28 infrastructure in China; and China has declared the Hainan Islands to be a special economic
29 zone for medical tourism; therefore be it
30

31 RESOLVED, That our American Medical Association reaffirm Ethical Opinion E-6.1.1,
32 "Transplantation of Organs from Living Donors," and believes that transplant surgeons,
33 especially those who come to the United States for training in transplant surgery, must agree to
34 these guidelines, and that American medical and hospital institutions not be complicit in any
35 ethical violations or conflicts of interest (New HOD Policy); and be it further

1 RESOLVED, That our AMA representatives to the World Medical Association request an
 2 independent, interdisciplinary (not restricted to transplant surgeons), transparent investigation
 3 into the Chinese practices of organ transplantation including (but not limited to): the source of
 4 the organs as well as the guidelines followed; and to report back on these issues as well as the
 5 status of Prisoners of Conscience as sources of transplantable organs (Directive to Take
 6 Action); and be it further

7
 8 RESOLVED, That our AMA call upon the U.S. Government to protect the large number of
 9 transplant tourists by implementing legislation to regulate the evolving, ethical challenges by
 10 initiating a Reciprocal Transplant Transparency Act which would blacklist countries that do not
 11 meet the same transparency and ethical standards practiced in the U.S. (such as the public
 12 listing of annual transplant numbers by every transplant center to permit scrutiny). (Directive to
 13 Take Action)

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

Received: 09/27/18

RELEVANT AMA POLICY

E-6.1.1 Transplantation of Organs from Living Donors

Donation of nonvital organs and tissue from living donors can increase the supply of organs available for transplantation, to the benefit of patients with end-stage organ failure. Enabling individuals to donate nonvital organs is in keeping with the goals of treating illness and relieving suffering so long as the benefits to both donor and recipient outweigh the risks to both.

Living donors expose themselves to harm to benefit others; novel variants of living organ donation call for special safeguards for both donors and recipients.

Physicians who participate in donation of nonvital organs and tissues by a living individual should:

- (a) Ensure that the prospective donor is assigned an advocacy team, including a physician, dedicated to protecting the donors well-being.
- (b) Avoid conflicts of interest by ensuring that the health care team treating the prospective donor is as independent as possible from the health care team treating the prospective transplant recipient.
- (c) Carefully evaluate prospective donors to identify serious risks to the individual's life or health, including psychosocial factors that would disqualify the individual from donating; address the individual's specific needs; and explore the individual's motivations to donate.
- (d) Secure agreement from all parties to the prospective donation in advance so that, should the donor withdraw, his or her reasons for doing so will be kept confidential.
- (e) Determine that the prospective living donor has decision-making capacity and adequately understands the implications of donating a nonvital organ, and that the decision to donate is voluntary.
- (f) In general, decline proposed living organ donations from unemancipated minors or legally incompetent adults, who are not able to understand the implications of a living donation or give voluntary consent to donation.
- (g) In exceptional circumstances, enable donation of a nonvital organ or tissue from a minor who has substantial decision-making capacity when:
 - (i) the minor agrees to the donation;
 - (ii) the minor's legal guardians consent to the donation;
 - (iii) the intended recipient is someone to whom the minor has an emotional connection.
- (h) Seek advice from another adult trusted by the prospective minor donor when circumstances warrant, or from an independent body such as an ethics committee, pastoral service, or other institutional resource.
- (i) Inform the prospective donor:

- (i) about the donation procedure and possible risks and complications for the donor;
- (ii) about the possible risks and complications for the transplant recipient;
- (iii) about the nature of the commitment the donor is making and the implications for other parties;
- (iv) that the prospective donor may withdraw at any time before undergoing the intervention to remove the organ or collect tissue, whether the context is paired, domino, or chain donation; and
- (v) that if the donor withdraws, the health care team will report simply that the individual was not a suitable candidate for donation.
- (j) Obtain the prospective donor's separate consent for donation and for the specific intervention(s) to remove the organ or collect tissue.
- (k) Ensure that living donors do not receive payment of any kind for any of their solid organs. Donors should be compensated fairly for the expenses of travel, lodging, meals, lost wages, and medical care associated with the donation only.
- (l) Permit living donors to designate a recipient, whether related to the donor or not.
- (m) Decline to facilitate a living donation to a known recipient if the transplantation cannot reasonably be expected to yield the intended clinical benefit or achieve agreed on goals for the intended recipient.
- (n) Permit living donors to designate a stranger as the intended recipient if doing so produces a net gain in the organ pool without unreasonably disadvantaging others on the waiting list. Variations on donation to a stranger include:
 - (i) prospective donors who respond to public solicitations for organs or who wish to participate in a paired donation ("organ swap," as when donor-recipient pairs Y and Z with incompatible blood types are recombined to make compatible pairs: donor-Y with recipient-Z and donor-Z with recipient-Y);
 - (ii) domino paired donation;
 - (iii) nonsimultaneous extended altruistic donation ("chain donation").
- (o) When the living donor does not designate a recipient, allocate organs according to the algorithm that governs the distribution of deceased donor organs.
- (p) Protect the privacy and confidentiality of donors and recipients, which may be difficult in novel donation arrangements that involve many patients and in which donation-transplant cycles may be extended over time (as in domino or chain donation).
- (q) Monitor prospective donors and recipients in proposed nontraditional donation arrangements for signs of psychological distress during screening and after the transplant is complete.
- (r) Support the development and maintenance of a national database of living donor outcomes to support better understanding of associated harms and benefits and enhance the safety of living donation.

[AMA Principles of Medical Ethics: I,V,VII,VIII](#)

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(I-18)

Introduced by: Heart Rhythm Society
American College of Cardiology
American Society for Echocardiography
Society for Cardiovascular Angiography and Interventions

Subject: Eliminating Barriers to Automated External Defibrillator Use

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Sudden cardiac arrest (SCA) affects over 40,000 people in the public environment
2 annually in the United States and early and prompt bystander automated external defibrillator
3 (AED) use has been shown to be key for survival from SCA¹; and
4

5 Whereas, Current research have shown that AEDs are used in less than 5% of public SCA
6 events²; and
7

8 Whereas, Despite efforts to establish AED availability in schools, workplaces and public spaces
9 (as supported by AMA Policy H-130.938), studies have shown that the majority of the public
10 either cannot identify an AED or are not aware of where AEDs are located²; and
11

12 Whereas, Due to the combination of inadequate public education about AED use, presence of
13 labeling on AEDs that state "Trained Responders Only", and variations in state legislation with
14 respect to legal protection for "Good Samaritans" who use AEDs, most laypersons are not
15 aware that AEDs can be used by non-medical professionals³; therefore be it
16

17 RESOLVED, That our American Medical Association update its policy on cardiopulmonary
18 resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the
19 importance of AED use and public awareness of AED locations, by using solutions such as
20 integrating AED sites into widely accessible mobile maps and applications (New HOD Policy);
21 and be it further
22

23 RESOLVED That our AMA urge AED vendors to remove labeling from AED stations that
24 stipulate that only trained medical professionals can use the defibrillators (Directive to Take
25 Action); and be it further
26

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

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

Received: 09/26/18

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RELEVANT AMA POLICY**Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938**

Our AMA: (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation; (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs; (3) encourages the American public to become trained in CPR and the use of automated external defibrillators; (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held; (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events; (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices; (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel; (8) supports the development and use of universal connectivity for all defibrillators; and (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use.

Citation: (CCB/CLRPD Rep. 3, A-14; Appended: Res. 211, I-14; Modified: Res. 919, I-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(I-18)

Introduced by: Medical Student Section

Subject: Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, 1,981 people were injured and 590 people were killed during mass shootings in 2017;¹ and

Whereas, Research suggests that an incident of a mass shooting increases the probability of another mass shooting in the immediate future, with the increased probability lasting for an average of thirteen days and abetting an average of 0.30 new events, suggesting a contagion effect;^{2,3} and

Whereas, The contagion effect was previously demonstrated in suicides in the mid-1990s and led to the development of media coverage guidelines by the CDC and more recently by the WHO;^{4,5,6} and

Whereas, Multiple media organizations, including Associated Press Managing Editors and the National Press Photographers Association, have contributed to the publication and adherence of reporting guidelines for suicide that largely reflect the CDC's published guidelines;^{7,8} and

Whereas, Appropriate media coverage of suicide may lead to a reduction in suicide rates, an effect known as the Papageno effect;⁹⁻¹² and

Whereas, Analysis of media coverage of mass shootings followed by copycat incidents of mass shootings indicate a media contagion effect;^{2,3,9,13} therefore be it

RESOLVED, That our American Medical Association encourage the Centers for Disease Control and Prevention, the National Institute of Mental Health, the Associated Press Managing Editors, the National Press Photographers Association, and other relevant organizations to develop guidelines for media coverage of mass shootings in a manner that is unlikely to provoke additional incidents. (New HOD Policy)

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

Received: 09/28/18

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RELEVANT AMA POLICY

Mass Media Violence and Film Ratings H-515.974

Redressing Shortcomings in the Current System: The AMA: (1) will speak out against the excessive portrayal of violence in the news and entertainment media, including newscasts, movies, videos, computer games, music and print outlets, and encourage the depiction of the medical, social and legal consequences of violence by the media;

(2) advises physicians to counsel parents about the known effects of media violence on children's behavior and encouraging them to reduce the amount of violent programming viewed by their children;

(3) monitors changes in the current ratings system and working through state medical societies to inform physicians and their patients about these changes; and

(4) supports all other appropriate measures to address and reduce television, cable television, and motion picture violence.

Citation: BOT Rep. 18, A-94; Modified: Res. 417, I-95; Appended: Sub. Res. 419, A-98;
Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmation: A-13 ; Reaffirmation: A-18

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;

(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and

(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

Citation: Res. 1011, A-16; Reaffirmation: A-18

Physicians and the Public Health Issues of Gun Safety D-145.997

Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

Citation: (Res. 410, A-13)

Epidemiology of Firearm Injuries D-145.999

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms.

Citation: Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13; Reaffirmation: A-18

Firearm Related Injury and Death: Adopt a Call to Action H-145.973

Our AMA endorses the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.

Citation: Res. 214, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(I-18)

Introduced by: Medical Student Section

Subject: Increasing Firearm Safety to Prevent Accidental Child Deaths

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, 1.7 million children live in homes with unlocked, loaded firearms and 1 in 3 homes with children have one or more firearms;¹ and

Whereas, A study found that 50.2% of children were often in homes that contained firearms, including their own and other homes;² and

Whereas, Studies on unintentional shootings have found that from 2005 to 2014, roughly 20,000 American minors were killed or seriously injured in accidental shootings; the majority of those killed in these tragic accidents were aged 12 or younger;^{3,4} and

Whereas, Studies have found that in firearm-owning households with children, there exists a significant reporting gap between those who actually own the firearm and those who do not regarding the type, number, and storage status of firearms in the home;^{5,6} and

Whereas, In some cases, the parent who does not own the firearm may be unaware that there is a firearm in the house at all;^{5,6} and

Whereas, The American Academy of Pediatrics (AAP) recommends that pediatricians include questions about the presence and availability of firearms in their patient history and urge parents owning firearms to take action to prevent children from gaining access to those firearms;⁷ and

Whereas, AMA Policy H-145.990 encourages physicians to educate patients on the dangers of firearms to children, but H-145.990 does not address the issue of disparities in reporting firearms between adults in households;⁸ and

Whereas, Various firearm product safety features exist that have proven to reduce youth firearm injuries, such as grip safeties, magazine disconnect devices, and personalization of firearms;⁹ and

Whereas, A magazine disconnect device physically prevents a firearm from being discharged if the magazine has been taken out, even if the chamber still has a round in it;¹⁰ and

Whereas, The U.S. General Accounting Office estimates 31% of accidental firearm deaths might be prevented by the addition of a child-proof safety lock (8%) and a loading indicator (23%), which indicates whether a firearm is loaded and if it still contains rounds in the chamber;⁹ and

Whereas, The AAP's Council on Injury, Violence, and Poison Prevention recommends safe storage and firearm safety features (i.e. trigger locks, lock boxes, gun safes) and supports the funding of research related to the prevention of firearm injury;⁷ and

Whereas, The California Department of Justice declared any center-fire semi-automatic pistol to be an "unsafe handgun" if it does not have a chamber load indicator or a magazine disconnect mechanism;¹¹ and

Whereas, Research spending on firearm injuries conducted by the CDC fell by 96% from 1996 to 2012;¹² and

Whereas, A study concluded that between 2004 and 2015, research on national firearm violence was significantly underfunded and understudied relative to other leading causes of death, receiving less than 1.6% of the \$1.4 billion researchers predicted should be allocated to study a public health issue with a similar number of deaths annually;¹³ and

Whereas, Existing AMA policy H-145.979 supports legislation that holds firearm owners legally responsible for injury or death caused by a child gaining access to a firearm;¹⁴ and

Whereas, Child Access Prevention (CAP) laws, which encourage firearm owners to be conscious of how they store their firearms, may be more preventive than AMA policy because they range from strict laws that hold gun owners criminally liable when a child could likely gain access to their gun to more lenient forms that only hold gun owners criminally liable if a child actually obtains or uses the gun;¹⁵ and

Whereas, CAP laws are currently active in twenty-seven states as well as Washington D.C.;¹⁶ and

Whereas, Most states that enacted CAP laws experienced greater declines in the rate of unintentional firearm deaths for children ages 0 to 14 compared with states not enacting the laws;¹⁷ and

Whereas, Only states with felony prosecution for violation of CAP laws had statistically significant declines in unintentional firearm deaths when adjusted for firearm prevalence;¹⁷ and

Whereas, when CAP laws were implemented, self-inflicted firearm injuries fell by 64% for youth ages 18 and under, but did not decrease for adults based on data from the Agency for Healthcare Research and Quality's Nationwide Inpatient Sample (NIS);¹⁸ therefore be it

RESOLVED, That our American Medical Association advocate for enactment of Child Access Prevention laws in all 50 states or as federal law. (New HOD Policy)

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

Date Received: 09/24/18

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RELEVANT AMA POLICY:

Prevention of Unintentional Shooting Deaths Among Children H-145.979

Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.

Citation: (Res. 204, I-98; Reaffirmed: BOT Rep. 23, A-09)

Prevention of Firearm Accidents in Children H-145.990

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(2) encourages state medical societies to work with other organizations to increase public education about firearm safety; and (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children.

Citation: Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 04, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(I-18)

Introduced by: Wisconsin

Subject: A Public Health Case for Firearm Regulation

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Firearm deaths are a leading cause of preventable suicide, homicide, injury and
2 disability in the USA;ⁱⁱ and
3

4 Whereas, In the USA in 2016, there were on average 97 firearm deaths per day, 35,476 total,ⁱ
5 two thirds of which were suicides affecting mostly young black men and older white men;^{i,ii} and
6

7 Whereas, In the ten years ending in 2016, deaths from firearms totaled more than the
8 cumulative deaths of American soldiers in WW II;ⁱⁱ and
9

10 Whereas, The Second Amendment to the U.S. Constitution specifies, “A well-regulated militia
11 being necessary to the security of a free state, the right of the people to keep and bear arms
12 shall not be infringed;”ⁱⁱⁱ and
13

14 Whereas, A militia is “generally an army or some other fighting organization of non-professional
15 soldiers, citizens of a nation, or subjects of a state, who can be called upon for military service
16 during a time of need;”^{iv} and
17

18 Whereas, The Second Amendment to the U.S. Constitution literally mandates that such militia
19 be “well-regulated;” and
20

21 Whereas, Firearm regulation that does not violate the Second Amendment to the U.S.
22 Constitution is not difficult to imagine; and
23

24 Whereas, A recent state-of-the-art systematic review of firearm regulation in the USA showed
25 that firearm regulation was generally associated with decreased rates of firearm homicides;ⁱⁱ and
26

27 Whereas, In that same review, laws that particularly strengthened background checks and
28 permit-to-purchase are associated with firearm homicide reductions of 29-40%;ⁱⁱ and
29

30 Whereas, The U.S. Congress in 1996 inserted language into the Centers for Disease Control
31 and Prevention appropriation bills that essentially prevented it from conducting and funding
32 firearm-related research;”^v and
33

34 Whereas, Firearms are exceedingly efficient and lethal killing instruments easily classifiable as
35 extremely hazardous to the health of the public; and
36

37 Whereas, U.S. physicians have begun to organize to promote firearm legislation and regulation^{vi}
38 suggesting the time for action by organized medicine has arrived; therefore be it

- 1 RESOLVED, That our American Medical Association support a public health approach to
- 2 evidence-based firearm laws and regulations that do not conflict with the Second Amendment to
- 3 the U.S. Constitution (New HOD Policy); and be it further
- 4
- 5 RESOLVED, That our AMA oppose barriers to firearm safety. (New HOD Policy)

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

Received: 09/25/18

RELEVANT AMA POLICY

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

- Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
- (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
 - (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
 - (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
 - (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
 - (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
 - (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18

Epidemiology of Firearm Injuries D-145.999

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms.

Citation: Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13; Reaffirmation: A-18

Data on Firearm Deaths and Injuries H-145.984

The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.

Citation: (Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-13)

Removing Restrictions on Federal Funding for Firearm Violence Research D-145.994

Our AMA will provide an informational report on recent and current organizational actions taken on our existing AMA policies (e.g. H-145.997) regarding removing the restrictions on federal funding for firearms violence research, with additional recommendations on any ongoing or proposed upcoming actions.

Citation: Res. 201, I-16

Gun Regulation H-145.999

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

Citation: Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and

(2) will actively lobby Congress to lift the gun violence research ban.

Citation: Res. 1011, A-16; Reaffirmation: A-18

ⁱ Wintemute GJ. What you can do to stop firearm violence. *Ann Intern Med* 2017;167:886-887.

ⁱⁱ Rowhani-Rahbar A, Rivara FP. Firearm injury after gun shows: Evidence to gauge the potential impact of Regulatory Interventions. *Ann Intern Med* 2017;167:888-889.

ⁱⁱⁱ https://en.wikipedia.org/wiki/Second_Amendment_to_the_US_Constitution. Accessed January 19, 2018.

^{iv} <https://en.wikipedia.org/wiki/Militia>, accessed January 29, 2018

^v Kellerman AL, Rivara FP. Silencing the science on gun research. *JAMA* 2013;309:549-550.

^{vi} Kuehn BM. Medical News and Perspectives: Physicians Join Frontline Efforts to Curb Gun Injuries, Deaths. *JAMA* January 2018, in print.

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

REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION (I-18)
Competency of Senior Physicians
(Reference Committee C)

EXECUTIVE SUMMARY

Older physicians remain an essential part of the physician workforce as they continue to practice into their 70s and 80s. Although some studies of physicians have shown decreasing practice performance with increasing years in medical practice, the effect of age on any individual physician's competence can be highly variable. The call for increased accountability by the public has led regulators and policymakers to consider implementing some form of age-based competency screening to assure safe and effective practice. In addition, some hospitals and medical systems have initiated age-based screening, but there is no national standard. Older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice. It is critical that physicians take the lead in developing standards for monitoring and assessing their personal competency and that of fellow physicians to head off a call for nationally implemented mandatory retirement ages or imposition of guidelines by others that are not evidenced based.

The Council on Medical Education studied this issue and prepared its first report on this topic in 2015. American Medical Association (AMA) Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," was adopted and the Council, in collaboration with the Senior Physicians Section, identified organizations to work together to develop preliminary guidelines for screening and assessing the competency of the senior/late career physician. The AMA Work Group on Assessment of Senior/Late Career Physicians included key stakeholders that represented physicians, medical specialty societies, accrediting and certifying organizations, hospitals and other health care institutions, and patients' advocates as well as content experts who research physician competence and administer assessment programs.

The work group concurred that it was important to investigate the current screening practices and policies of the state medical and osteopathic boards, medical societies, large U.S. health systems, and remediation programs as well as to collect data and review the current literature to learn more about age and risk factors associated with the assessment of senior/late career physicians in the United States and internationally. This report summarizes the activities of the work group and additional research findings on this topic.

This report also outlines a set of guiding principles developed by the Council with extensive feedback from members of the work group as well as from other content experts who research physician competence and administer assessment programs. The guiding principles provide direction and serve as a reference for the development of guidelines for screening and assessing senior/late career physicians. The underlying assumption is that guidelines must be based on evidence and on the principles of medical ethics. Furthermore, guidelines should be relevant, supportive, fair, equitable, and transparent, and not result in undue cost or burden to senior physicians. The primary driver for the establishment of guidelines should be to fulfill the ethical obligation of the profession to the health of the public and patient safety.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-18

Subject: Competency of Senior Physicians

Presented by: Carol Berkowitz, MD, Chair

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

American Medical Association (AMA) Policy D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians,” directs our AMA to: “1) identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior/late career physicians remain able to provide safe and effective care for patients; and 2) convene organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings.”

The first report on this topic, Council on Medical Education Report 5-A-15, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians,” recommended that a work group be convened to further study the topic of assessing the competency of senior/late career physicians. This report summarizes the activities of the work group and additional research findings on this topic. This report also outlines a set of guiding principles to provide direction and serve as a reference for the development of guidelines for screening and assessing senior/late career physicians.

BACKGROUND: SCOPE OF THE ISSUE

Older physicians remain an essential part of the physician workforce. The total number of physicians 65 years and older has increased greatly from 50,993 in 1975 to 300,752 in 2017.¹ Physicians 65 and older currently represent 26.6 percent of all physicians in the United States.¹ Within this age group, two-fifths (40.6 percent) are actively engaged in patient care, while half (52.7 percent) are listed as inactive in the AMA Physician Masterfile.¹ Many physicians are hesitant to retire and may continue to practice into their 70s and 80s due to professional satisfaction, increased life expectancy, and concerns regarding financial security.²

Evidence supports findings that physical health and some cognitive abilities decline with aging.³ Research shows that cognitive dysfunction is more prevalent among older adults, although aging does not necessarily result in cognitive impairment.⁴ The effect of age on any individual physician’s competence can be highly variable, and aging is just one of several factors that may impact performance.^{2,5} Other factors may influence clinical performance, i.e., practice setting, lack of board certification, high clinical volume, certain specialty practices, etc.^{6,7} Fatigue, stress, burnout, and health issues unrelated to aging are also risk factors that can affect clinical performance.⁷ Performance also may be broadly determined by characteristics ranging from intelligence to personality.³ However, some attributes relevant to the practice of medicine—such as

wisdom, resilience, compassion, and tolerance of stress—may actually increase as a function of aging.^{5,8-11}

Although age alone may not be associated with reduced competence, the variation around cognitive abilities as physicians age suggests that the issue cannot be ignored. There are a limited number of valid tools for measuring competence/performance, but these tools are primarily used when a physician is “referred for cause.” In addition, physicians’ practices vary throughout the United States and from specialty to specialty. A few hospitals have introduced mandatory age-based evaluations, but there is no national standard.¹²⁻¹³ Furthermore, there is cultural resistance to externally imposed assessment approaches and concern about discriminatory regulatory policies and procedures.

Knowing when to give up practice remains an important decision for most doctors and a critically difficult decision for some.¹⁴ For this reason, physicians with decades of experience and contributions to medicine and to their patients, as they experience health changes that may or may not allow continued clinical practice, deserve the same sensitivity and respect afforded their patients.¹⁵ Shifting away from procedural work, allocating more time with individual patients, using memory aids, and seeking input from professional colleagues might help physicians successfully adjust to the cognitive changes that accompany aging.^{5,14}

It is in physicians’ best interest to proactively address issues related to aging in order to maintain professional self-regulation. Self-regulation is an important aspect of medical professionalism, and helping colleagues recognize their declining skills is an important part of self-regulation.¹⁶ Furthermore, contemporary methods of self-regulation (e.g., clinical performance measurement; continuing professional development requirements, including novel performance improvement continuing medical education programs; and new and evolving maintenance of certification programs) have been created by the profession to meet shared obligations for quality assurance and patient safety.

WORK GROUP MEETINGS

To fulfill the directive of Policy D-275.956, the Council on Medical Education, in collaboration with the Senior Physicians Section, identified organizations to participate in a joint effort to develop preliminary guidelines for screening and assessing the senior/late career physician. As summarized below, one work group meeting and two conference calls were convened to develop a research agenda that could guide those interested in this field and serve as the basis for guidelines supported by research findings.

March 16, 2016 Work Group Meeting

The work group meeting, held March 16, 2016, brought together key stakeholders that represented physicians, medical specialty societies, accrediting and certifying organizations, hospitals and other health care institutions, and patients’ advocates as well as content experts who research physician competence and administer assessment programs. Work group participants concurred that this first meeting raised important issues related to the rationale for developing guidelines to screen and assess the competence and practice performance of senior physicians, which are challenging for a number of reasons. Discussion centered around the evidence and factors related to competency and aging physicians, existing and needed policies, screening and assessment approaches, and legal requirements and challenges. Although current evidence and preliminary research pointed toward the need for developing guidelines, most work group participants felt that additional information/data should be gathered on aging physicians’ competence and practice performance. In

1 addition, the participants felt that a set of guiding principles should be developed to reflect the
 2 values and beliefs underlying any guidelines that may be developed for screening and assessing
 3 senior/late career physicians.

4
 5 *July 19, 2016 Work Group Conference Call*

6
 7 The purpose of this conference call was to convene a smaller group of participants to develop
 8 guiding principles to support the subsequent development of guidelines to screen and assess
 9 senior/late career physicians. During the call, the conversation focused upon the thresholds at
 10 which screening/assessment should be required. Although physicians of all ages can be assessed
 11 “for cause,” the group discussed whether age alone is a sufficient cause for some kind of
 12 monitoring beyond what is typical for all physicians. Other factors discussed included the influence
 13 of practice setting and medical specialty, as well as the metrics and standards for different settings
 14 that would have to be developed to determine at “what age” and “how do you test,” etc. The need
 15 for surveillance, associated risk factors, and the ability to take appropriate steps, if needed, were
 16 also discussed. It was noted that there is a need to be able to fairly and equitably identify physicians
 17 who may need help while assuring patient safety. It was also noted that very few hospitals have
 18 specific age guidelines, and that there was evidence that the number of disciplinary actions increase
 19 at ages 65 and 70. The cost of and who will pay for screening/assessments were also discussed.

20
 21 The group felt that more information and data were needed before the guiding principles could be
 22 finalized and agreed to reconvene after gathering more information and studying evidence-based
 23 data from the United States and other countries related to age and risk factors.

24
 25 *December 15, 2017 Work Group Conference Call*

26
 27 The purpose of this conference call was to reconvene the same smaller group of participants to
 28 review the literature and data that had been gathered, and to finalize guiding principles to support
 29 the subsequent development of guidelines to screen and assess senior/late career physicians.
 30 Background information to help guide the development of the guiding principles included:

- 31
 32 1. Results from a survey of members of the Federation of State Medical Boards (FSMB),
 33 Council of Medical Specialty Societies (CMSS), and International Association of Medical
 34 Regulatory Authorities (IAMRA) regarding the screening and assessment of senior
 35 physicians.
 36
 37 2. A literature review of available data related to senior physician screening and assessment,
 38 focusing on international work in this area.
 39
 40 3. Data from large health systems regarding their screening and assessment policies and
 41 procedures.

42
 43 Survey Results Related to Screening and Assessing Senior Physicians

44
 45 To support the development of guiding principles, data were gathered through surveys of
 46 professional associations (CMSS), state medical boards (FSMB), and international regulatory
 47 authorities (IAMRA). The goal was to learn if these organizations had processes in place to screen
 48 and assess senior physicians for clinical or cognitive competence, and if not, whether they had
 49 thought about developing such screening and assessment processes.

The survey data showed that most respondents were not screening or assessing senior physicians. A slightly larger number of respondents have thought about this, but those numbers were still fairly small.

Most respondents did not have clinical or cognitive screening/competence assessment policies in place. In addition, most did not know (42, or 46.7 percent) or were unsure (26, or 28.9 percent) whether other organizations had age-based screening in place. Regarding whether age-based screening should be included within physician wellness programs, 28 (32.9 percent) said yes, while nine (10.6 percent) said no, and 48 (56.5 percent) were unsure.

Respondents were asked if their organizations/boards offered educational resources regarding the effects of age on physician practice; eight (9.2 percent) said yes, 72 (82.8 percent) said no, and seven (8.0 percent) were unsure. The survey also asked organizations if they were interested in having resources that promoted physician awareness of screening aging physicians in practice. Very few groups offered these types of resources, but 100 percent (11) of IAMRA respondents, 60.8 percent (31) of FSMB respondents, and 25 percent (3) of CMSS respondents were interested in offering them.

Highlights from the Literature Review

A review of current literature focusing on age and risk factors associated with the assessment of senior/late career physicians in the United States and internationally is summarized below.

Peer-reviewed studies recently published focus on institutional policies related to cognitive assessment of senior physicians. Dellinger et al. concluded that as physicians age, a required cognitive evaluation combined with a confidential, anonymous feedback evaluation by peers and coworkers regarding wellness and competence would be beneficial both to physicians and their patients.¹⁷ The authors also recommended that large professional organizations identify a range of acceptable policies to address the aging physician, while leaving institutions the flexibility to customize the approach.¹⁷ Institutions such as Cooper University Health Care in Camden, New Jersey, are developing late career practitioner policies that include cognitive assessment with peer review and medical assessment to assure the hospital and physicians that competency is intact and that physicians can continue to practice with confidence.¹⁸

Studies related to professionalism, self-reporting, and peer review indicate that these methods are not always reliable.^{16, 19-20} Since early “red flags” of cognitive impairment may include prescription errors, billing mistakes, irrational business decisions, skill deficits, patient complaints, office staff observations, unsatisfactory peer review, patient injuries, or lawsuits, Soonsawat et al. encouraged improved reporting of impaired physicians by patients, peers, and office staff.² LoboPrabhu et al. suggested that either age-related screening for cognitive impairment should be initiated, or rigorous evaluation after lapses in standard of care should be the norm regardless of age.²¹

Any screening process needs to achieve a balance between protecting patients from harm due to substandard practice while at the same time ensuring fairness to physicians and avoiding any unnecessary reductions in workforce.³ A recent study of U.S. senior surgeons showed that a steady proportion of surgeons, even in the oldest age group (>65), are still active in new surgical innovations and challenging cases.²² Individual and institutional considerations require a dialogue among the interested parties to optimize the benefits while minimizing the risks for both.²³⁻²⁴

In Canada, the aging medical workforce presents a challenge for medical regulatory authorities charged with protecting the public from unsafe practice. Adler and Constantinou note that normal

aging is associated with some cognitive decline as part of the aging process, but physicians, who are highly educated individuals with advanced degrees may be less at risk.¹⁴

A review of the aging psychiatric workforce in Australia showed how specific cognitive and other skills required for the practice of psychiatry vary from those applied by procedural specialists.²⁵ The Australian medical boards are responsible for protecting the public from unsafe medical practice. There is some uniformity in the way that Australian regulatory bodies deal with impairment that supports the dual goals of protecting the public and rehabilitating the physician.²⁶ However, there are no agreed upon guidelines to help medical boards decide what level of cognitive impairment in a physician may put the public at risk.¹⁴ In Australia, the primary approach to dealing with older physicians (age 55 and older) is individualized and multi-levelled, beginning with assessment, followed by rehabilitation where appropriate; secondary measures proposed for older impaired physicians include early notification and facilitating career planning and timely retirement.²⁶

It is the responsibility of licensing bodies in New Zealand, Canada, and the United Kingdom to use reasonable methods to determine whether performance remains acceptable.²⁷ However, high performance by all physicians throughout their careers cannot be fully ensured.

A better understanding of physician aging and cognition can inform more effective approaches to continuous professional development and lifelong learning in medicine—a critical need in a global economy, where changing technology can quickly render knowledge and skills obsolete.⁴ The development of recertification programs, such as maintenance of certification (MOC) by the member boards of the American Board of Medical Specialties, provides an opportunity to study the knowledge base across the professional lifespan of physicians.²⁸⁻²⁹ For example, a recent study of initial certification and MOC examinees in the subspecialty of forensic psychiatry using a common item test question bank compared the two examinee groups' performance and demonstrated that performance for those younger than 50 was similar to those 60 and older, and that diplomates recertifying for the second time outperformed those doing so for the first time.³⁰

The Royal Australasian College of Surgeons developed strategies to support senior surgeons over 65 years of age (expected to be about 25 percent of surgeons by 2050) and a position statement that provides clear guidelines to aging surgeons, with a focus on continuing professional development.³¹⁻³² An assessment of the competence of practicing physicians in New Zealand, Canada, and the United Kingdom showed that “maintenance of professional standards” by continuing education did not identify the poorly performing physician; rather, assessment of clinical performance was needed.²⁷ The most common approach to assessment may be responsive—following a complaint—or periodic, either for all physicians or for an identified high-risk group. However, a single, valid, reliable, and practical screening tool is not available.²⁷

A literature review conducted in Europe to explore the effects of aging on surgeons' performance and to identify current practical methods for transitioning surgeons out of practice at the appropriate time and age, suggested that competence should be assessed at an individual level, focusing on functional ability over chronological age; this may inform retirement policies for surgeons, which differ worldwide.²² Research conducted in Canada suggested that some interventions (external support, deliberate practice, and education and testing) might prove successful in remediating older physicians, who should be tested more thoroughly.³³

Careful planning, innovative thinking, and the incorporation of new patterns of medical practice are all part of this complex transition of timing into retirement in the United States.^{23,34} A literature review that looked at retirement ages for doctors in different countries found that there is no

mandatory retirement age for doctors in most countries.³⁵ Anecdotal reports published in the *British Medical Journal* suggest that retirement has never been easy and is getting harder for some physicians because requirements for reappraisal and other barriers are discouraging some from considering part-time work after retirement.³⁶⁻³⁷ In Canada, Ireland, and India, the retirement age (65) is limited to public sectors only, but older physicians can continue to practice in the private sector.³⁵ In Russia and China, the mandated retirement age is 60 for men and 55 for women.³⁵

Studies show that doctors can mitigate the impact of cognitive decline by ceasing procedural work, allocating more time to each patient, using memory aids, seeking advice from trusted colleagues, and seeking second opinions.¹⁴ Peisah, et al. (Australia) proposed a range of secondary and primary prevention measures for dealing with the problem of the older impaired doctor; these included educating the medical community, encouraging early notification, and facilitating career planning and timely retirement of older doctors.²⁶ Racine (Canada) suggested that physicians retire before health or competency issues arise.³⁸ Lee (Canada) suggested that older practicing physicians consider slowing down in aspects of practice that require rapid cognitive processing and listen carefully to the concerns of colleagues, patients, friends, and family.³⁹ The University of Toronto, Department of Surgery, has developed Guidelines for Late Career Transitions that require each full-time faculty surgeon to undergo an annual assessment of academic and surgical activity and productivity. As surgeons age, the University creates individual plans for a decrease in on-call surgical responsibilities and encourages late-career surgeons to engage in greater levels of teaching, research, and administration.⁴⁰

How Some U.S. Organizations Are Addressing the Screening and Assessment of Competency of Senior Physicians

Since the call for increased accountability by the public has led regulators and policymakers to consider implementing some form of age-based competency screening to assure safe and effective practice,⁵ the work group concurred that it was important to investigate the current screening practices and policies of state medical and osteopathic boards, medical societies, large U.S. health systems, and remediation programs. Some of the more significant findings are summarized below.

All physicians must meet state licensure requirements to practice medicine in the United States. In addition, some hospitals and medical systems have initiated age-based screening,¹²⁻¹³ but there is no national standard. Older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice.

The American College of Surgeons (ACS) explored the challenges of assessing aging surgeons. Recognizing that the average age of the practicing surgeon is rising and approximately one-third of all practicing surgeons are 55 and older, the ACS was concerned that advanced age may influence competency and occupational performance. In January 2016, the ACS Board of Governors' Physician Competency and Health Workgroup published a statement that emphasized the importance of high-quality and safe surgical care.³⁹ The statement recognized that surgeons are not immune to age-related decline in physical and cognitive skills and stressed the importance of a healthy lifestyle. The ACS recommended that, starting at ages 65 to 70, surgeons undergo a voluntary and confidential baseline physician examination and visual testing for overall health assessment, with regular reevaluation thereafter. In addition, the ACS encouraged surgeons to voluntarily assess their neurocognitive function using confidential online tools and asserted a professional obligation to disclose any concerning findings, as well as inclusion of peer review reports in the re-credentialing process.⁴¹

1 The American College of Obstetricians and Gynecologists (ACOG) recommends that when
2 evaluating an aging physician, focus should be placed on the physician's quality of care provided
3 to patients.⁴² ACOG's recommendations regarding the later-career obstetrician–gynecologist also
4 state that: 1) it is important to establish systems-based competency assessments to monitor and
5 address physicians' health and the effect age has on performance and outcomes; 2) workplace
6 adaptations should be adopted to help obstetrician–gynecologists transition and age well in their
7 practice and throughout their careers; and 3) to avoid the potential for legal challenges, hospitals
8 should address the provisions of the Age Discrimination in Employment Act, making sure that
9 assessments are equitably applied to all physicians, regardless of age.⁴²

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

24
25 The University of California, San Diego, Physician Assessment and Clinical Education (PACE)
26 Program is the largest assessment and remediation program for health care professionals in the
27 country. Recently, PACE conducted a pilot screening project to assess physicians. Thirty volunteer
28 physicians, aged 50 to 83, were recruited to participate in the screening regimen. Preliminary data
29 analysis showed that a number of senior physicians performed less than optimally (seven of 30
30 participants). However, when age-based capacity was reviewed (i.e., did those individuals between
31 50 to 59 or those between 60 to 69 years old perform better than those age 70 and older), the results
32 were not statistically significant. The pilot study did have sufficient power to reach significance.
33 However, the trend of the data was that older physicians did perform less optimally. It was also
34 noted that 75 percent of the physicians who didn't perform well on the MicroCog (a computerized
35 assessment that detects early signs of cognitive impairment) were still working in a clinical
36 capacity. The study did not include enough participants to provide a breakdown on specialties.

37 38 PROPOSED GUIDING PRINCIPLES

39
40 The Council on Medical Education proposes a set of guiding principles as a basis for developing
41 guidelines for the screening and assessment of senior/later career physicians. The underlying
42 assumption is that guidelines must be based on evidence and on the principles of medical ethics.
43 Furthermore, guidelines should be relevant, supportive, fair, equitable, and transparent, and not
44 result in undue cost or burden to senior physicians. The primary driver for the establishment of
45 guidelines should be to fulfill the ethical obligation of the profession to the health of the public and
46 patient safety.

47
48 The Council developed the following eight guiding principles with extensive feedback from
49 members of the AMA Work Group on Assessment of Senior/Late Career Physicians as well as
50 feedback from other content experts who research physician competence and administer screening
51 and assessment programs.

1. *Evidence-based:* The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Current research suggests that physician competency and practice performance decline with increasing years in practice. However, research also suggests that the effect of age on an individual physician's competency can be highly variable, and wide variations are seen in cognitive performance with aging.
2. *Ethical:* Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency.
3. *Relevant:* Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.
4. *Accountable:* The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.
5. *Fair and equitable:* The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians' practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. When public health or patient safety is directly threatened, removal from practice is one potential outcome.
6. *Transparent:* Guidelines, procedures, or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment.
7. *Supportive:* Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive.
8. *Cost conscious:* Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to senior physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed senior physicians. Similar procedures and screening mechanisms should be available to senior physicians who are not employed by hospitals and health care systems.

AMA POLICY

The AMA has policy in which it urges members of the profession to discover and rehabilitate if possible, or exclude if necessary, the physicians whose practices are incompetent, and to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, are in need of help or whose practices are incompetent (H-275.998). AMA policy urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions

that impair a physician's current ability to practice medicine (H-275.978[6]). AMA policy also reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and CME activities (H-300.973 and H-275.996). These and other related policies are attached (see Appendix).

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education concurs that physicians should be allowed to remain in practice as long as patient safety is not endangered, and they are providing appropriate and effective treatment. However, data and anecdotal information support the development of guidelines for the screening and assessment of senior/late career physicians. The variations around cognitive skills as physicians age, as well as the changing demographics of the physician workforce, are also key factors contributing to this need. It is critical that physicians take the lead in developing standards for monitoring and assessing their personal competency and that of fellow physicians to head off a call for nationally implemented mandatory retirement ages or imposition of guidelines by others. The guiding principles outlined in this report provide direction and serve as a reference for setting priorities and standards for further action.

The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed.

1. That our American Medical Association (AMA) make available to all interested parties the Assessment of Senior/Late Career Physicians Guiding Principles:
 - a) Evidence-based: The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Current research suggests that physician competency and practice performance decline with increasing years in practice. However, research also suggests that the effect of age on an individual physician's competency can be highly variable, and wide variations are seen in cognitive performance with aging.
 - b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency.
 - c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.
 - d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.
 - e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians' practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. When public health or patient safety is directly threatened, removal from practice is one potential outcome.
 - f) Transparent: Guidelines, procedures or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment.

- 1 g) Supportive: Education and/or remediation practices that result from screening and /or
2 assessment procedures should be supportive of physician wellness, ongoing, and proactive.
- 3 h) Cost conscious: Procedures and screening mechanisms that are distinctly different from
4 “for cause” assessments should not result in undue cost or burden to senior physicians
5 providing patient care. Hospitals and health care systems should provide easily accessible
6 screening assessments for their employed senior physicians. Similar procedures and
7 screening mechanisms should be available to senior physicians who are not employed by
8 hospitals and health care systems. (New HOD Policy)
9
- 10 2. That our AMA encourage the Federation of State Medical Boards, Council of Medical
11 Specialty Societies, and other interested organizations to develop educational materials on the
12 effects of age on physician practice for senior/late career physicians. (Directive to Take Action)
13
- 14 3. That Policy D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career
15 Physicians,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal note: \$1,000

APPENDIX: AMA POLICIES

D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians"

Our American Medical Association: (1) will identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior/late career physicians remain able to provide safe and effective care for patients; and (2) will convene organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings. (CME Rep. 5, A-15)

H-275.936, "Mechanisms to Measure Physician Competency"

Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency. (Res. 320, I-98 Amended: Res. 817, A-99 Reaffirmed: CME Rep. 7, A-02 Reaffirmed: CME Rep. 7, A-07 Reaffirmed: CME Rep. 16, A-09 Reaffirmed in lieu of Res. 313, A-12 Modified: Res. 309, I-16)

H-275.996, "Physician Competence"

Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 302, A-10; Reaffirmed in lieu of Res. 320, A-14)

H-275.998, "Physician Competence"

Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful. (4) State governments to provide to their state medical licensing boards resources

adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine. (5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent. (6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.) (CME Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03; Reaffirmed: CME Rep. 2, A-13)

H-275.978, "Medical Licensure"

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;

(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;

(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;

(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;

(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;

(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);

(7) urges licensing boards to maintain strict confidentiality of reported information;

(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;

(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;

(10) urges all physicians to participate in continuing medical education as a professional obligation;

(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;

(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;

(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;

(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;

- (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;
 - (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;
 - (17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;
 - (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;
 - (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;
 - (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;
 - (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and
 - (22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.
- (CME Rep. A, A-87 Modified: Sunset Report, I-97 Reaffirmation A-04 Reaffirmed: CME Rep. 3, A-10 Reaffirmation I-10 Reaffirmed: CME Rep. 6, A-12 Appended: Res. 305, A-13 Reaffirmed: BOT Rep. 3, I-14)

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REPORT 3 OF THE COUNCIL ON MEDICAL EDUCATION (I-18)
Developing Physician-Led Public Health/Population Health Capacity in Rural Communities
(Reference Committee C)

EXECUTIVE SUMMARY

American Medical Association (AMA) Policy D-295.311, “Developing Physician Led Public Health/Population Health Capacity in Rural Communities,” asks that our AMA, with the participation of the appropriate educational and certifying entities, study innovative approaches that could be developed and/or implemented to support interested physicians as they seek qualifications and credentials in preventive medicine/public health to strengthen public health leadership, especially in rural communities.

Our country’s need for public health and preventive medicine investments continues to grow, spurred by many factors (e.g., the closing of rural hospitals, lack of access to urban health care, maintaining the viability of safety-net hospitals, the opioid crisis, increasing prevalence of lifestyle diseases, etc.), and resource deficiencies have been documented in both rural and urban communities. It is well documented that investments in preventive medicine and public health are cost effective and save lives. Therefore, support for physicians seeking qualifications and credentials in these areas is desirable.

A wide range of organizations, both physician- and non-physician focused, offers education and resources regarding this important topic. Rural training tracks and programs are available at the UME, GME, and postgraduate level, and multiple national public/population health organizations offer strategies and solutions to individuals and entities seeking to improve their public health knowledge and gain new skills. The AMA also offers resources that help physicians expand their knowledge base in population/public health, including STEPSforward™ modules and the Health Systems Science textbook, which focuses on providing a fundamental understanding of how health care is delivered, how health care professionals work together to deliver that care, and how the health system can improve patient care and health care delivery. Programs are also available to address the multiple complex issues related to the advancement of women’s health and fulfilling women’s potential for leadership in education, research, and clinical practice.

This report focuses on existing and planned educational interventions that are intended to help physicians and medical students develop professional skills and qualifications related to preventive, public, population, and rural health. The report: 1) outlines previous Council on Medical Education reports related to this topic; 2) summarizes relevant available resources; and 3) makes recommendations to the House of Delegates.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-I-18

Subject: Developing Physician-Led Public Health/Population Health Capacity in Rural Communities

Presented by: Carol Berkowitz, MD, Chair

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

INTRODUCTION

American Medical Association (AMA) Policy D-295.311, “Developing Physician Led Public Health/Population Health Capacity in Rural Communities,” asks that our AMA, with the participation of the appropriate educational and certifying entities, study innovative approaches that could be developed and/or implemented to support interested physicians as they seek qualifications and credentials in preventive medicine/public health to strengthen public health leadership, especially in rural communities. Previous reports on this topic include Council on Medical Education Report 11-A-09, “Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum”; Council on Medical Education Report 8-A-08, “One-Year Public Health Training Options for All Specialties”; and Council on Medical Education Report 12-A-07, “One-Year Public Health Training Options for All Specialties.”

This report focuses on existing and planned educational interventions that are intended to help physicians and medical students develop professional skills and qualifications related to preventive, public, population, and rural health. The report: 1) outlines previous Council on Medical Education reports related to this topic; 2) summarizes relevant available resources; and 3) makes recommendations to the HOD.

BACKGROUND

Our country’s need for public health and preventive medicine investments continues to grow, spurred by a number of factors (e.g., the closing of rural hospitals, lack of access to urban health care, maintaining the viability of safety-net hospitals, the opioid crisis, and the increasing prevalence of lifestyle diseases), and resource deficiencies have been documented in both rural and urban communities.^{1,2,3,4} The Affordable Care Act (ACA) reduced the number of uninsured persons due to Medicaid expansion, health insurance marketplaces, the employer mandate to provide health insurance, and a provision permitting young adults to remain on a parent’s health insurance plan until 26 years of age. However, an estimated 27 million U.S. citizens remain uninsured.⁵ Inpatient, emergency, and ambulatory services for this population, as well as for millions of other patients, particularly Medicaid beneficiaries, continue to rely on safety-net health systems that provide health care regardless of the patient’s ability to pay. Although a few programs, such as Emergency Medicaid, provide some payment for lifesaving treatments and limited recovery services, longer-term care, such as psychiatric care, is also disproportionately delivered by safety-net health systems.⁵

1 In 2017, Congress eliminated the individual mandate penalty for not having health insurance
2 (effective 2019);⁴ this will have the greatest effect on safety net hospitals that are already in poor
3 financial condition, especially those in rural and suburban areas. Without the mandate, more people
4 are likely to forgo insurance and, if they later need care, will seek that care from safety-net health
5 systems. Since the total demand for uncompensated care in a health care market does not change,
6 evidence suggests that there is nearly complete spillover of uncompensated care to neighboring
7 hospitals.⁵

8
9 It is well documented that investments in preventive medicine and public health are cost effective
10 and save lives.^{6,7,8,9} Therefore, support for physicians seeking qualifications and credentials in these
11 areas is desirable.

12
13 The AMA Council on Medical Education (CME) has addressed related topics on several previous
14 occasions.

15
16 CME Report 11-A-09, “Integrating Content Related to Public Health and Preventive Medicine
17 Across the Medical Education Continuum,” identified ways in which medical students are educated
18 in public health and reported on strategies for integrating public health-related content across the
19 medical education continuum. The report further recommends that our AMA encourage medical
20 schools, schools of public health, graduate medical education programs, and key stakeholder
21 organizations to develop and implement longitudinal educational experiences in public health for
22 medical students in the pre-clinical and clinical years and to provide both didactic and practice-
23 based experiences in public health for residents in all specialties including public health and
24 preventive medicine; and that our AMA encourage the Liaison Committee on Medical Education
25 and the Accreditation Council for Graduate Medical Education to examine their standards to assure
26 that public health-related content and skills are included and integrated as appropriate in the
27 curriculum.

28
29 CME Reports 8-A-08 and 12-A-07, both titled “One-Year Public Health Training Options for All
30 Specialties,” concluded that a strong public health infrastructure is necessary to further
31 advancements that have been made in public health as well as to combat existing and future threats
32 to the nation’s health. Further, these reports noted that concern over the nation’s ability to produce
33 the number of well-trained public health physicians needed to address these public health needs has
34 been growing, and that there is clear need for a cadre of physicians prepared for public health
35 practice.

36
37 CME Report 4-A-10, “Educational Strategies to Promote Physician Practice in Underserved
38 Areas,” does not specifically address public or population health. However, it does link the
39 importance of exposure to rural training experiences to eventual rural practice.

40 41 DISCUSSION

42
43 A wide range of organizations, both physician- and non-physician-focused, offers education and
44 resources regarding this important topic.

45 46 *American Board of Preventive Medicine*

47
48 The American Board of Preventive Medicine (ABPM) offers four pathways to achieve board
49 certification in Public Health and General Preventive Medicine.

- Residency Pathway

The ABPM Residency Pathway is open to all individuals “who have completed an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency of not less than two years, in the specialty area for which certification is being sought.”¹⁰ Participation in the pathway requires a supervised year of postgraduate clinical training, including at least 10 months of direct patient care; completion of an ACGME-accredited residency training program accredited in the specialty area for which certification is being pursued; successful completion of an MPH or equivalent graduate degree; and demonstration of current practice if more than 24 months have passed since completion of residency training (unless otherwise engaged in specialty or subspecialty training).

- Complementary Pathway

The ABPM Complementary Pathway, meant to engage mid-career physicians seeking to change their specialty practice, requires two years of supervised postgraduate clinical training in an ACGME-accredited training program; a year of ACGME-accredited residency training in the specialty area in which certification is sought; postgraduate level coursework in epidemiology, biostatistics, health services administration, environmental health sciences, and social and behavioral health sciences; and proof of current practice (unless in training) for two of the last five years.

- Special Pathway

The ABPM Special Pathway allows ABPM diplomates with current certification in Aerospace Medicine, Occupational Medicine, or Public Health and General Preventive Medicine to pursue certification in another ABPM primary specialty. (Diplomates with current subspecialty certification in Addiction Medicine, Clinical Informatics, Medical Toxicology, and Undersea and Hyperbaric Medicine are not eligible for this pathway.) In addition to ABPM specialty certification, candidates must also be able to demonstrate they have been practicing (or training) for two of the last five years in the specialty/subspecialty area in which they are seeking additional certification.

- Alternative Pathway

The ABPM Alternative Pathway is only applicable to those individuals who graduated from medical school prior to January 1, 1984, and who do not qualify for certification through one of the three previously described pathways. In addition to the graduation year requirement, candidates must have completed a year of supervised postgraduate training in an ACGME-accredited GME program, including at least 10 months of direct patient care; postgraduate level coursework in epidemiology, health services administration, environmental health sciences, and social and behavioral health sciences; and demonstration of practice for at least two of the last five years. For this category, the required, demonstrated number of years in practice is dependent on ABMS member board certification status; completion of residency training in the specialty area in which certification is sought; and possession of an MPH degree or equivalent.

American College of Physicians

The American College of Physicians (ACP) sponsors an ACP Leadership Academy, which provides leadership training and resources.¹¹ The Academy offers an 18-month certificate program in conjunction with the American Association for Physician Leadership, including a combination of formal training (through webinar or live coursework), group discussions, and a capstone project. The Leadership Academy also offers free webinars,¹² several of which (population health, leadership principles for women in medicine) are directly related to this report.

1 Recently, the ACP released a position paper noting that, “The American College of Physicians
 2 recommends that social determinants of health and the underlying individual, community, and
 3 systemic issues related to health inequities be integrated into medical education at all levels.”¹³ The
 4 paper also reviews particular health challenges associated with rural locations.

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

6 Many Accelerating Change in Medical Education Consortium members have been working to
 7 address population, public, and rural health education at the UME level.¹⁴

- 10 • The partnership between A.T. Still University’s School of Osteopathic Medicine in
 11 Arizona and the National Association of Community Health Centers embeds second-,
 12 third-, and fourth-year medical students in rural health centers. Additionally, second-year
 13 students participate in a year-long course in epidemiology, biostatistics, and preventive
 14 medicine, during which they work with community stakeholders and health centers to
 15 identify and address local issues of community concern.
- 16 • The Brody School of Medicine at East Carolina University integrates a population health
 17 component into its comprehensive longitudinal core curriculum.
- 18 • Case Western Reserve University School of Medicine incorporates a patient navigator
 19 model into its curriculum, and medical student navigators learn to use and create registries
 20 for population health management in specific population groups.
- 21 • The curriculum at Dell Medical School at the University of Texas at Austin is built around
 22 instruction in leadership, which is incorporated into all four years of education. During the
 23 third year, students can choose to focus on specific areas of study, including population
 24 health.
- 25 • Upon joining the consortium, Florida International University Herbert Wertheim College
 26 of Medicine enhanced its “Green Family Foundation Neighborhood Health Education
 27 Learning Program” (NeighborhoodHELP™), which provides a longitudinal,
 28 interprofessional community-based experience for medical students and partnerships with
 29 local hospitals.
- 30 • The blended learning curriculum at the Mayo Clinic School of Medicine focuses on six
 31 content domains, one of which is population-centered care. Students can also pursue an
 32 additional 12 credits to receive a master’s degree in health care delivery science, which
 33 includes instruction in population and preventive health. Further, Mayo has created
 34 milestones for students related to population health in alignment with ACGME
 35 competencies.
- 36 • The New York University School of Medicine’s Health Care by the Numbers curriculum
 37 uses very large de-identified datasets to train students to improve the health of populations.
- 38 • Ohio University Heritage College of Osteopathic Medicine integrates population health
 39 into its continuous, longitudinal curriculum.
- 40 • The University of Connecticut School of Medicine’s MDelta curriculum has been
 41 specifically designed so that all students can achieve a certificate in public health, with a
 42 specific focus on disparities and the social determinants of health. Additionally, the school
 43 has incorporated the Regenstrief EHR Clinical Learning Platform into the MDelta
 44 curriculum. This platform includes large numbers of de-identified patient records, allowing
 45 students to research population health issues.
- 46 • The University of Nebraska Medical Center College of Medicine, through its focus on
 47 interprofessional education, has established official partnerships with its colleges of
 48 nursing, public health, pharmacy, dentistry, and allied health professions.
- 49 • The University of North Dakota School of Medicine and Health Sciences incorporates
 50 training in the use of telemedicine to connect remote patients and providers at multiple
 51

locations to address rural health care needs. Simulation training mimics common cases seen in rural settings.

- Medical students at the University of Texas Rio Grande Valley School of Medicine learn onsite in unincorporated *colonias* along the U.S./Mexico border, allowing incorporation of oral histories into the medical record. Students also have the opportunity to shadow community health workers, or *promotoras*, as part of a curriculum that simulates the process necessary to convince legislators to fund similar interventions.
- In Vanderbilt University School of Medicine's longitudinal, four-year Foundations of Health Care Delivery course, third- and fourth-year medical students complete self-directed modules in a number of topic areas, including advanced population health and public health.
- The Warren Alpert Medical School of Brown University offers nine courses in its Master of Science degree in population medicine, covering social determinants of health, disparities, instruction in population medicine research, leadership, and epidemiology. Some of these courses are required for all students, even if not pursuing the master's degree. Students are also required to prepare a thesis on population medicine.

Combined UME, GME, and Postgraduate Educational Programs and Rural and Public/Population Health Training Tracks

The topic of public/population health recently has been the focus of increased attention and study for physician learners,^{15, 16} and a number of public health training opportunities are available to learners beginning at the UME level. According to the Association of American Medical Colleges (AAMC), 87 MD-MPH programs are currently offered at institutions spanning 37 states and the District of Colombia.¹⁷ The American Association of Colleges of Osteopathic Medicine (AACOM) also maintains a list of dual degree programs. As of June 2018, 17 institutions offered combined DO-MPH degrees.¹⁸

In addition to MD- or DO-MPH programs, some medical schools offer specific experiences in rural training. For example, the Rural Opportunities in Medical Education (ROME) program at the University of North Dakota School of Medicine is available to third-year students and involves a multi-month, interdisciplinary assignment to a rural primary care setting.¹⁹ Likewise, the Wisconsin Academy for Rural Medicine (WARM) is a training program intended to address rural physician shortages and ultimately improve the health of rural Wisconsin.²⁰ Of WARM graduates, 91 percent practice in Wisconsin, and 52 percent practice primary care medicine. Similar to the ROME program, the Rural Physician Associate Program (RPAP) offered by the University of Minnesota Medical School provides third-year medical students a hands-on opportunity to live and train in rural communities.²¹

Due to limited access to health care in some regions of West Virginia, the Rural Health Partners Scholarship Program is collaborating with third-year medical students who are interested in matching into a Charleston Area Medical Center (CAMC) Residency Program.²² Scholarship recipients receive mentoring during their fourth year of medical school in preparation for the residency program; experience a one-month rural health rotation at one of the participating rural sites; complete a required research project; and then receive a \$10,000 scholarship when they successfully graduate from medical school and match into one of the participating CAMC residency programs. The candidates must be medical students at West Virginia University, Marshall University, or West Virginia School of Osteopathic Medicine. The educational base and residency enable students to develop clinical and leadership experiences uniquely targeted for rural and underserved areas.²⁰ (The "All-in Policy" for waivers from the National Resident Matching Program is currently under review. Certain CAMC departments such as family medicine may

pursue and be awarded such a match waiver. Applicants will be notified of waiver status as that information becomes available.)²⁰

At the GME level, the ACGME Common Program Requirements include expectations that issues related to public health be included in the educational program for all specialties. Among the ACGME's six competencies, Systems-Based Practice is especially relevant to the integration of public health. This competency states that "Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care." This includes "advocating for quality patient care and optimal patient care systems...incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate," and "understanding health care finances and its impact on individual patients' health decisions."²³

Several individual specialties also incorporate training in public health-related matters. Accreditation requirements for pediatrics, for example, require structured activities designed to prepare pediatric residents to be effective advocates for the health of children in the community. Additionally, many family medicine residencies teach community-oriented primary care, which integrates public health principles into primary care practice.

Combined residency programs also are available for trainees interested in pursuing experience in public/population health. Of the 73 currently accredited residency training programs in preventive medicine,²⁴ three are combined family medicine/preventive medicine programs, and six are combined internal medicine/preventive medicine programs.²⁵ Furthermore, of the 11,300 ACGME-accredited programs in all specialties, 357 indicated that they offer a separate rural track.²⁶

For example, Texas Tech University has established a rural health residency training program in family medicine at four sites (Andrews, Fort Stockton, Sweetwater, and Alpine). The program began as a 1115 waiver project/grant of \$3 million and has been successful enough that each of the hospitals involved is now contributing funding to support the program. The program requires residents to complete a one-year core program and then two years of training at a rural site in West Texas. The goal is to place physicians in the region who will stay and provide care to the residents of these locations. Texas currently has the largest number of at-risk hospitals of any state in the nation (75).²⁷

For medical school graduates, public/population health training opportunities exist beyond combined residency training programs. The AAMC curates a list of public health pathways.²⁸ Currently, the website identifies 57 public health fellowship, faculty development, and continuing education opportunities.

At the postgraduate level, the Centers for Disease Control and Prevention (CDC), through its Epidemic Intelligence Service (EIS) Program, offers two-year, postgraduate programs that train physicians (and others) in infectious disease investigation, thereby preparing them to respond to public health threats both domestically and internationally. In 2017, 71 EIS officers were trained through this program, 65 of whom were U.S. citizens or permanent residents.²⁹

National Public Health Organizations

Multiple national public/population health organizations currently offer strategies and solutions to individuals and entities seeking to improve their public health knowledge and gain new skills.

- 1 • The American Association of Public Health Physicians (AAPHP), founded to provide a
2 voice to physician directors of state and local health departments at the national level,
3 offers publicly available educational resources, ranging from ethics in public health, food
4 safety, fracking, and gun violence/racism prevention.³⁰
5
- 6 • In addition to a collection of reports, educational webinars, and policy statements on a
7 broad range of public health topics, the American Public Health Association offers a
8 substantial number of internships (not limited to physicians-in-training or physicians) in
9 topics ranging from environmental health, government relations, injury and violence
10 prevention, and public health policy, as well as a Public Health Fellowship in Government.
11 This fellowship places future public health leaders into positions as staff members for
12 elected officials in Congress.³¹
13
- 14 • The National Association of County and City Health Officials (NACCHO) offers a
15 publicly available “toolbox” focusing on public health tools created by and for members of
16 the public health community. Tools range from emergency preparedness and vector control
17 to public engagement and injury and violence prevention. NACCHO also offers a library
18 of best practices related to chronic disease management intended to help local health
19 departments stay current in both knowledge and interventions.³² Furthermore, NACCHO
20 University is an online learning hub where public health professionals can access training
21 and develop competencies.³³ Finally, NACCHO Consulting works with local public health
22 departments on research and evaluation projects, performance improvement, workforce
23 development, and public health topics.³⁴
24
- 25 • The CDC has compiled a resource list “for health professional students, educators, and
26 health professionals to learn more about issues affecting individuals at a population level,
27 to become more familiar with other population health issues, to integrate public health into
28 existing curricula, and for increased collaboration with public health.”³⁵ This list comprises
29 collaborative efforts, competencies, curricula, training opportunities, and peer-reviewed
30 publications, among other resources.
31
- 32 • The Public Health Leadership Forum, funded by the Robert Wood Johnson Foundation,
33 seeks to engage public health leaders and stakeholders in efforts that promote
34 transformation in the field of public health.³⁶ The Forum has worked on a number of
35 impactful projects, including the development of a set of foundational public health
36 services for public health departments and the visioning of the future of high-functioning
37 public health departments.
38
- 39 • The Association of State and Territorial Health Officials (ASTHO) has developed a list of
40 educational tools and resources that support cooperation between public health and primary
41 care organizations.³⁷ ASTHO also provides resources to state and territorial health officials
42 regarding proven and cost-effective population health improvement approaches.³⁸
43
- 44 • The National Network of Public Health Institutes serves as the national coordinating center
45 for ten regional public health training centers and 40 additional local sites to “offer high-
46 quality training, tools, and resources for thousands of professionals engaged in the critical
47 work of advancing public health practice and improving population health,”³⁹ and serves as
48 facilitator of the Public Health Learning Network. These training centers and affiliate sites
49 focus on building skills in change management, communication, diversity/inclusion,
50 information/analytics, leadership, policy engagement, problem solving, resource

management, and systems thinking on a wide range of topics in communities across the United States.

- In conjunction with other organizations, the Council of State and Territorial Epidemiologists currently sponsors four fellowships in applied epidemiology, public health informatics, health systems integration, and informatics (training in place).⁴⁰ Fellowship recipients commit to two years of on-the job training onsite at a state or local health agency, in step with recommendations from the National Academy of Medicine (NAM) that “State and large local health departments, in conjunction with medical schools and schools of public health, expand postresidency fellowships in public health that emphasize transition into governmental public health practice.”⁴¹
- Also supportive of this NAM recommendation are fellowships sponsored by the Association of Schools and Programs of Public Health (ASPPH). ASPPH notes that more than 2,200 “ASPPH Fellows and Interns have been placed at state/local health departments and federal agency offices across the U.S., and in 26 countries worldwide where U.S. agencies are assisting Ministries of Health.”⁴²

Additional AMA Resources

The AMA’s STEPS ForwardTM library includes a module on Project ECHOTM, which is specifically designed to help coordinate care across rural areas in need of certain specialty care.⁴³ Additionally, the AMA published a STEPS ForwardTM module on social determinants of health in September 2018.⁴⁴

Further, the AMA’s groundbreaking work in the discipline of health systems science (HSS) has highlighted the importance of teaching physician learners how to advocate for their patients and communities and understand the socioecological determinants of health, health care policy, and health care economics. The AMA’s HSS textbook⁴⁵ is the first text that focuses on providing a fundamental understanding of how health care is delivered, how health care professionals work together to deliver that care, and how the health system can improve patient care and health care delivery. Along with the basic and clinical sciences, HSS is rapidly becoming a crucial “third pillar” of medical science, requiring a practical, standardized curriculum with an emphasis on understanding the role of human factors, systems engineering, leadership, and patient improvement strategies that will help transform the future of health care and ensure greater patient safety. As of the writing of this report, the AMA’s HSS textbook is in use by 32 medical schools across the country, and a second edition is scheduled to be released at the end of 2019.

PROMOTING PUBLIC HEALTH LEADERSHIP

A review of the medical education literature finds recommendations for strategies to improve the development of public health leadership capacity across the medical education continuum. Such strategies include instituting specific public health leadership curricula;⁴⁶ looking at how public health leadership is currently defined;⁴⁷ focusing on the specific skills and talents public health leaders require;⁴⁸ and considering the risks and benefits of engaging non-clinician celebrity diplomacy.⁴⁹

Additional studies focus more specifically on the limits of public health leadership programs. Grimm et al. note that the number of public health leadership programs has declined since 2012 and consequently proposed a framework for greater uniformity in leadership development and evaluation.⁵⁰ Others note that evaluation of public health leadership interventions is often lacking.⁵¹

Leadership Roles for Women

Although their numbers in leadership roles are increasing, women remain underrepresented in the top echelons of health care leadership, and gender differences exist in the types of leadership roles women do attain.⁵² The Department of Health and Human Services Office on Women's Health, through its National Center of Excellence initiative, has encouraged the institutions participating in the initiative to address the multiple complex issues that are impeding the advancement of women in education, research, and clinical practice and are preventing the realization of women physicians' full potential for leadership.⁵³

Considering the many ways that sex and gender influence disease presentation and patient management, there have been various studies and initiatives to improve the integration of these topics into medical education. A growing network of medical and academic institutions, professional organizations, government agencies, and individuals who share a vision of women's health and sex- and gender-specific medicine are developing materials for medical education and clinical practice. The Laura W. Bush Institute for Women's Health and the Texas Tech University Medical Center Women's Health Committee have developed a website that provides resources on sex- and gender-specific health and continuing medical education programs. The Sex and Gender Women's Health Collaborative maintains a digital resource library of sex- and gender-specific materials. The Office of Research on Women's Health website offers a series of courses for researchers, clinicians, and students to provide a foundation for sex and gender accountability in medical research and treatment. Articles that present a case for the inclusion of sex- and gender-focused content into medical education curricula are summarized in a [bibliography](#) that was recently developed for the AMA Council on Medical Education website.

Programs are also available to educate women on the practices needed to enhance their leadership skills and effectiveness. One example is the Emerging Women Executives in Health Care Program, offered through the Harvard T.H. Chan School of Public Health.⁵⁴

RELEVANT AMA POLICY

The AMA has extensive policy related to this topic; these policies are listed in the Appendix.

SUMMARY AND RECOMMENDATIONS

Leadership in public and population health remains an important topic deserving of continued interest within the community of medicine. In addition to the ongoing focus on available training opportunities related to public/population health leadership for physicians and medical students, attention should be directed to the future composition of the country's public health leaders. A recent study found that 73 percent of deans of schools of public health were male, and 70 percent received their terminal degree more than 35 years ago; 64 percent of state health directors received their terminal degree more than 25 years ago; and 26 percent of state health directors hold no terminal degree.¹⁴ There is no evidence to suggest that these individuals are anything other than effective, dedicated leaders who are passionate about promoting public/population health in their communities and throughout the country. However, these statistics should perhaps spark a discussion within the medical community regarding how individuals are currently encouraged and incentivized to enter public health leadership positions, and how to ensure that current public/population health leaders are actively engaging in relevant lifelong learning.

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

- 1 1. That Policy D-295.311, “Developing Physician Led Public Health / Population Health
2 Capacity in Rural Communities,” be rescinded, as having been fulfilled by this report.
3 (Rescind HOD Policy)
4
- 5 2. That our American Medical Association (AMA) reaffirm the following policies:
6 D-295.327, “Integrating Content Related to Public Health and Preventive Medicine Across
7 the Medical Education Continuum”
8 D-305.964, “Support for the Epidemic Intelligence Service (EIS) Program and Preventive
9 Medicine Residency Expansion”
10 D-305.974, “Funding for Preventive Medicine Residencies”
11 H-425.982, “Training in the Principles of Population-Based Medicine”
12 D-440.951, “One-Year Public Health Training Options for all Specialties”
13 H-440.954, “Revitalization of Local Public Health Units for the Nation”
14 H-440.888, “Public Health Leadership”
15 H-440.969, “Meeting Public Health Care Needs Through Health Professions Education”
16 (Reaffirm HOD Policy)
17
- 18 3. That our AMA encourage the Association of American Medical Colleges (AAMC),
19 American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation
20 Council for Graduate Medical Education (ACGME) to highlight public/population health
21 leadership learning opportunities to all learners, but especially to women and those who are
22 underrepresented in medicine. (Directive to Take Action)
23
- 24 4. That our AMA encourage public health leadership programs to evaluate the effectiveness
25 of various leadership interventions. (Directive to Take Action)

Fiscal Note: \$1,000.

APPENDIX: RELEVANT AMA POLICY

8.11, “Health Promotion and Preventive Care”

Medicine and public health share an ethical foundation stemming from the essential and direct role that health plays in human flourishing. While a physician’s role tends to focus on diagnosing and treating illness once it occurs, physicians also have a professional commitment to prevent disease and promote health and well-being for their patients and the community.

The clinical encounter provides an opportunity for the physician to engage the patient in the process of health promotion. Effective elements of this process may include educating and motivating patients regarding healthy lifestyle, helping patients by assessing their needs, preferences, and readiness for change and recommending appropriate preventive care measures. Implementing effective health promotion practices is consistent with physicians’ duties to patients and also with their responsibilities as stewards of health care resources.

While primary care physicians are typically the patient’s main source for health promotion and disease prevention, specialists can play an important role, particularly when the specialist has a close or long-standing relationship with the patient or when recommended action is particularly relevant for the condition that the specialist is treating. Additionally, while all physicians must balance a commitment to individual patients with the health of the public, physicians who work solely or primarily in a public health capacity should uphold accepted standards of medical professionalism by implementing policies that appropriately balance individual liberties with the social goals of public health policies.

Health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients’ self-directed roles and responsibilities in maintaining health. In keeping with their professional commitment to the health of patients and the public, physicians should:

- (a) Keep current with preventive care guidelines that apply to their patients and ensure that the interventions they recommend are well supported by the best available evidence.
- (b) Educate patients about relevant modifiable risk factors.
- (c) Recommend and encourage patients to have appropriate vaccinations and screenings.
- (d) Encourage an open dialogue regarding circumstances that may make it difficult to manage chronic conditions or maintain a healthy lifestyle, such as transportation, work and home environments, and social support systems.
- (e) Collaborate with the patient to develop recommendations that are most likely to be effective.
- (f) When appropriate, delegate health promotion activities to other professionals or other resources available in the community who can help counsel and educate patients.
- (g) Consider the health of the community when treating their own patients and identify and notify public health authorities if and when they notice patterns in patient health that may indicate a health risk for others.
- (h) Recognize that modeling health behaviors can help patients make changes in their own lives.

Collectively, physicians should:

- (i) Promote training in health promotion and disease prevention during medical school, residency and in continuing medical education.
- (j) Advocate for healthier schools, workplaces and communities.
- (k) Create or promote healthier work and training environments for physicians.
- (l) Advocate for community resources designed to promote health and provide access to preventive services.
- (m) Support research to improve the evidence for disease prevention and health promotion.

H-225.949, “Medical Staff and Hospital Engagement of Community Physicians”

2. Our AMA encourages medical staffs and hospitals to engage community physicians, as appropriate, in medical staff and hospital activities, which may include but need not be limited to: (a) medical staff duties and leadership; (b) hospital governance; (c) population health management initiatives; (d) transitions of care initiatives; and (e) educational and other professional and collegial events.

D-295.327, “Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum”

1. Our AMA encourages medical schools, schools of public health, graduate medical education programs, and key stakeholder organizations to develop and implement longitudinal educational experiences in public health for medical students in the pre-clinical and clinical years and to provide both didactic and practice-based experiences in public health for residents in all specialties including public health and preventive medicine.
2. Our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.
3. Our AMA actively encourages the development of innovative models to integrate public health content across undergraduate, graduate, and continuing medical education.
4. Our AMA, through the Initiative to Transform Medical Education (ITME), will work to share effective models of integrated public health content.
5. Our AMA supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents.
6. Our AMA will urge the Centers for Medicare and Medicaid Services to include resident education in public health graduate medical education funding in the Medicare Program and encourage other public and private funding for graduate medical education in prevention and public health for all specialties

H-295.868, “Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training”

1. Our AMA recommends that formal education and training in disaster medicine and public health preparedness be incorporated into the curriculum at all medical schools and residency programs.
2. Our AMA encourages medical schools and residency programs to utilize multiple methods, including simulation, disaster drills, interprofessional team-based learning, and other interactive formats for teaching disaster medicine and public health preparedness.
3. Our AMA encourages public and private funders to support the development and implementation of education and training opportunities in disaster medicine and public health preparedness for medical students and resident physicians.
4. Our AMA supports the National Disaster Life Support (NDLS) Program Office’s work to revise and enhance the NDLS courses and supporting course materials, in both didactic and electronic formats, for use in medical schools and residency programs.
5. Our AMA encourages involvement of the National Disaster Life Support Education Consortium’s adoption of training and education standards and guidelines established by the newly created Federal Education and Training Interagency Group (FETIG).
6. Our AMA will continue to work with other specialties and stakeholders to coordinate and encourage provision of disaster preparedness education and training in medical schools and in graduate and continuing medical education.

7. Our AMA encourages all medical specialties, in collaboration with the National Disaster Life Support Educational Consortium (NDLSEC), to develop interdisciplinary and inter-professional training venues and curricula, including essential elements for national disaster preparedness for use by medical schools and residency programs to prepare physicians and other health professionals to respond in coordinated teams using the tools available to effectively manage disasters and public health emergencies.
8. Our AMA encourages medical schools and residency programs to use community-based disaster training and drills as appropriate to the region and community they serve as opportunities for medical students and residents to develop team skills outside the usual venues of teaching hospitals, ambulatory clinics, and physician offices.
9. Our AMA will make medical students and residents aware of the context (including relevant legal issues) in which they could serve with appropriate training, credentialing, and supervision during a national disaster or emergency, e.g., non-governmental organizations, American Red Cross, Medical Reserve Corps, and other entities that could provide requisite supervision.
10. Our AMA will work with the Federation of State Medical Boards to encourage state licensing authorities to include medical students and residents who are properly trained and credentialed to be able to participate under appropriate supervision in a national disaster or emergency.
11. Our AMA encourages physicians, residents, and medical students to participate in disaster response activities through organized groups, such as the Medical Response Corps and American Red Cross, and not as spontaneous volunteers.
12. Our AMA encourages teaching hospitals to develop and maintain a relocation plan to ensure that educational activities for faculty, medical students, and residents can be continued in times of national disaster and emergency.

D-305.964, "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion"

Our AMA will work to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program and work to support increased federal funding for preventive medicine residency training programs.

D-305.974, "Funding for Preventive Medicine Residencies"

Our AMA will work with the American College of Preventive Medicine, other preventive medicine specialty societies, and other allied partners, to formally support legislative efforts to fund preventive medicine training programs.

D-385.963, "Health Care Reform Physician Payment Models"

8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.
9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.
10. Our AMA encourages state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.

H-425.982, "Training in the Principles of Population-Based Medicine"

The AMA will continue to monitor and support the progress made by medical and public health organizations in championing disease prevention and health promotion; and will support efforts to bring schools of medicine and public health back into a closer relationship.

H-425.984, "Clinical Preventive Services"

Implications for Adolescent, Adult, and Geriatric Medicine: (1) Prevention should be a philosophy that is espoused and practiced as early as possible in undergraduate medical schools, residency training, and continuing medical education, with heightened emphasis on the theory, value, and implementation of both clinical preventive services and population-based preventive medicine. (2) Practicing physicians should become familiar with authoritative clinical preventive services guidelines and routinely implement them as appropriate to the age, gender, and individual risk/environmental factors applicable to the patients in the practice at every opportunity, including episodic/acute care visits. (3) Where appropriate, clinical preventive services recommendations should be based on outcomes-based research and effectiveness data. Federal and private funding should be increased for further investigations into outcomes, application, and public policy aspects of clinical preventive services.

H-425.986, "Challenges in Preventive Medicine"

It is the policy of the AMA that (1) physicians should become familiar with and increase their utilization of clinical preventive services protocols; (2) individual physicians as well as organized medicine at all levels should increase communication and cooperation with and support of public health agencies. Physician leadership in advocating for a strong public health infrastructure is particularly important; (3) physicians should promote and offer to serve on local and state advisory boards; and (4) in concert with other groups, physicians should study local community needs, define appropriate public health objectives, and work toward achieving public health goals for the community.

H-425.993, "Health Promotion and Disease Prevention"

The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; and (5) strongly emphasizes the important opportunity for savings in health care expenditures through prevention.

H-440.888, "Public Health Leadership"

Our AMA: (1) urges that appropriately trained and experienced licensed physicians (MDs or DOs) be employed by state and local health departments to be the responsible leader when patient care decisions are made, whether for individuals in the STD or TB Clinics or for the community at large when an epidemic is to be managed; and

(2) defines public health leadership and decision-making that promotes health and prevents disease in the community as the practice of medicine, requiring a licensed practitioner with all the skills, training, experience and knowledge of a public health trained physician.

H-440.892, “Bolstering Public Health Preparedness”

Our AMA supports: (1) the concept that enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be specifically targeted as among our nation’s highest priorities; and (2) in principle, the funding of research into the determinants of quality performance by public health agencies, including but not limited to the roles of Boards of Health and how they can most effectively help meet community needs for public health leadership, public health programming, and response to public health emergencies.

H-440.912, “Federal Block Grants and Public Health”

(1) Our AMA should collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated; such efforts may include the development of a common core of knowledge for public health and medical professionals, as well as educational vehicles to disseminate this information.

(2) Our AMA urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; and (c) involve national medical and public health organizations in deliberations on proposed changes in funding of public health programs.

(3) Our AMA will work with and through state and county medical societies to: (a) improve understanding of public health, including the distinction between publicly funded medical care and public health; (b) determine the roles and responsibilities of private physicians in public health, particularly in the delivery of personal medical care to underserved populations; (c) advocate for essential public health programs and services; (d) monitor legislative proposals that affect the nation’s public health system; (e) monitor the growing influence of managed care organizations and other third party payers and assess the roles and responsibilities of these organizations for providing preventive services in communities; and (f) effectively communicate with practicing physicians and the general public about important public health issues.

(4) Our AMA urges state and county medical societies to: (a) establish more collegial relationships with public health agencies and increase interactions between private practice and public health physicians to develop mutual support of public health and clinical medicine; and (b) monitor and, to the extent possible, participate in state deliberations to ensure that block grant funds are used appropriately for health-related programs.

(5) Our AMA urges physicians and medical societies to establish community partnerships comprised of concerned citizens, community groups, managed care organizations, hospitals, and public health agencies to: (a) assess the health status of their communities and determine the scope and quality of population- and personal-based health services in their respective regions; and (b) develop performance objectives that reflect the public health needs of their states and communities.

6. Our AMA: (a) supports the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, in order to assure preservation of many critical public health programs for chronic disease prevention and health promotion in California and nationwide, and to maintain training of the public health physician workforce; and (b) will communicate support of the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, to the US Congress.

D-440.951, "One-Year Public Health Training Options for all Specialties"

1. Our AMA encourages additional funding for public health training for more physicians. 2. Our AMA, in conjunction with other appropriate organizations, supports the work of relevant groups to initiate the development of specific physician competencies for physicians engaged in public health practice. 3. Our AMA will inform medical students and physicians of existing opportunities for physician training in preparation for public health practice.

H-440.954, "Revitalization of Local Public Health Units for the Nation"

The AMA (1) reaffirms its support of state and local health departments; (2) recommends that health departments be directed by well qualified public health trained physicians; and (3) urges federal, state and local governments to study public health and preventive services, and urges the allocation of necessary resources to maintain these services at a high level of quality.

H-440.960, "The IOM Report (The Future of Public Health) and Public Health"

Our AMA

(1) encourages medical societies to establish liaison committees through which physicians in private practice and officials in public health can explore issues and mutual concerns involving public health activities and private practice;
(2) seeks increased dialogue, interchange, and cooperation among national organizations representing public health professionals and those representing physicians in private practice or academic medicine;
(3) actively supports promoting and contributing to increased attention to public health issues in its programs in medical science and education;
(4) continues to support the providing of medical care to poor and indigent persons through the private sector and the financing of this care through an improved Medicaid program;
(5) encourages public health agencies, as the IOM report suggests, to focus on assessment of problems, assurance of healthy living conditions, policy development, and activities such as those mentioned in the "Model Standards";
(6) encourages physicians and others interested in public health programs to apply the messages and injunctions of the IOM report as these fit their own situations and communities; and
(7) encourages physicians in private practice and those in public health to work cooperatively, striving to ensure better health for each person and an improved community as enjoined in the Principles of Medical Ethics.

H-440.969, "Meeting Public Health Care Needs Through Health Professions Education"

(1) Faculties of programs of health professions education should be responsive to the expectations of the public in regard to the practice of health professions. Faculties should consider the variety of practice circumstances in which new professionals will practice. Faculties should add curriculum segments to ensure that graduates are cognizant of the services that various health care professionals and alternative delivery systems provide. Because of the dominant role of public bodies in setting the standards for practice, courses on health policy are appropriate for health professions education. Additionally, governing boards of programs of education for the health professions, as well as the boards of the institutions in which these programs are frequently located, should ensure that programs respond to changing societal needs. Health professions educators should be involved in the education of the public regarding health matters. Programs of health professions education should continue to provide care to patients regardless of the patient's ability

to pay and they should continue to cooperate in programs designed to provide health practitioners in medically underserved areas.

(2) Faculty and administrators of health professions education programs should participate in efforts to establish public policy in regard to health professions education. Educators from the health professions should collaborate with health providers and practitioners in efforts to guide the development of public policy on health care and health professions education.

H-450.933, "Clinical Data Registries"

1. Our AMA encourages multi-stakeholder efforts to develop and fund clinical data registries for the purpose of facilitating quality improvements and research that result in better health care, improved population health, and lower costs.

D-478.974, "Quality Improvement in Clinical / Population Health Information Systems"

Our American Medical Association will invite other expert physician associations into the AMA consortium to further the quality improvement of electronic health records and population health as discussed in the consortium letter of January 21, 2015 to the National Coordinator of Health Information Technology.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-I-18

Subject: Reconciliation of AMA Policy on Primary Care Workforce

Presented by: Carol Berkowitz, MD, Chair

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

INTRODUCTION

The goal of this report is to review, reconcile, and consolidate existing American Medical Association (AMA) policy on primary care workforce, eliminate duplication, and ensure that current policies are coherent and relevant. For each policy recommendation, a succinct but cogent justification is provided to support the proposed action. The most recent policy was deemed to supersede contradictory past AMA policies, and the language of each proposed policy was edited so that it is coherent and easily understood, without altering its meaning or intent.

POLICIES INCLUDED IN THIS REPORT

The following AMA policies are addressed in this report:

1. D-200.979, "Barriers to Primary Care as a Medical School Choice"
2. D-200.994, "Appropriations for Increasing Number of Primary Care Physicians"
3. H-200.956, "Appropriations for Increasing Number of Primary Care Physicians"
4. H-200.966, "Federal Financial Incentives and Medical Student Career Choice"
5. H-200.972, "Primary Care Physicians in the Inner City"
6. H-200.973, "Increasing the Availability of Primary Care Physicians"
7. H-200.975, "Availability, Distribution and Need for Family Physicians"
8. H-200.977, "Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians"
9. H-200.978, "Loan Repayment Programs for Primary Care Careers"
10. H-200.982, "Significant Problem of Access to Health Care in Rural and Urban Underserved Areas"
11. H-200.997, "Primary Care"
12. H-295.956, "Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers"
13. H-300.957, "Promoting Primary Care Services Through Continuing Medical Education"
14. H-310.973, "Primary Care Residencies in Community Hospitals"

SUMMARY AND RECOMMENDATIONS

This report encompasses a review of current AMA policies on primary care workforce to ensure such policy is consistent, accurate and up-to-date.

The new policy being proposed in recommendation 1, below, incorporates relevant portions of the 13 existing policies that are recommended for rescission in recommendation 2. Appendices A and B show a worksheet version and a clean text version, respectively, of the policy that is being proposed for adoption. Appendix C lists the 13 existing policies that are proposed for rescission.

Policy H-200.972, "Primary Care Physicians in the Inner City," contained elements that were not germane to the newly proposed policies. Accordingly, this policy is recommended for revision, as shown below, with the deleted portions to be reflected in the proposed policy. In addition, the policy's content and title have been expanded to reflect rural as well as urban populations of underserved patients.

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

1. That our American Medical Association (AMA) adopt as policy "Principles of and Actions to Address Primary Care Workforce" the language shown in column 1 in Appendix A to this report. (New HOD Policy)
2. That our AMA rescind the following policies, as shown in Appendix C:
 1. D-200.979, "Barriers to Primary Care as a Medical School Choice"
 2. D-200.994, "Appropriations for Increasing Number of Primary Care Physicians"
 3. H-200.956, "Appropriations for Increasing Number of Primary Care Physicians"
 4. H-200.966, "Federal Financial Incentives and Medical Student Career Choice"
 5. H-200.973, "Increasing the Availability of Primary Care Physicians"
 6. H-200.975, "Availability, Distribution and Need for Family Physicians"
 7. H-200.977, "Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians"
 8. H-200.978, "Loan Repayment Programs for Primary Care Careers"
 9. H-200.982, "Significant Problem of Access to Health Care in Rural and Urban Underserved Areas"
 10. H-200.997, "Primary Care"
 11. H-295.956, "Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers"
 12. H-300.957, "Promoting Primary Care Services Through Continuing Medical Education"
 13. H-310.973, "Primary Care Residencies in Community Hospitals" (Rescind HOD Policy)
3. That H-200.972, "Primary Care Physicians in the Inner City," be amended by addition and deletion, and a title change, to read as follows:

"Primary Care Physicians in Underserved Areas"

Our AMA should pursue the following plan to improve the recruitment and retention of physicians in ~~the inner city~~ underserved areas:

- (1) Encourage the creation and pilot-testing of school-based, ~~church~~ faith-based, and community-based urban/rural "family Hh 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 ~~use~~ involvement of retired physicians in underserved ~~urban~~ settings ~~of retired physicians~~, with appropriate mechanisms to ensure their competence.
- (95) Urge ~~urban~~ hospitals and medical societies to develop opportunities for physicians to work part-time to staff ~~urban~~ health clinics that help meet the needs of underserved patient populations.
- ~~(106)~~ Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who ~~serve the inner-city poor~~ help meet the needs of underserved patient populations.
- ~~(11) Urge medical schools to seek out those students whose profiles indicate a likelihood of practicing in underserved urban areas, while establishing strict guidelines to preclude discrimination.~~
- ~~(12) Encourage medical school outreach activities into secondary schools, colleges, and universities to stimulate students with these profiles to apply to medical school.~~
- ~~(13) Encourage medical schools to continue to change their curriculum to put more emphasis on primary care.~~
- ~~(14) Urge state medical associations to support the development of methods to improve physician compensation for serving this population, such as Medicaid case management programs in their respective states.~~

- 1 (157) Urge ~~urban~~ hospitals and medical centers to seek out the use of available military
2 health care resources and personnel, which can be used to ~~fill gaps in urban~~
3 ~~care~~ help meet the needs of underserved patient populations.
4
5 (16) ~~Urge CMS to explore the use of video and computer capabilities to improve access~~
6 ~~to and support for urban primary care practices in underserved settings.~~
7
8 (17) ~~Urge urban hospitals, medical centers, state medical associations, and specialty~~
9 ~~societies to consider the expanded use of mobile health care capabilities.~~
10
11 (18) ~~Continue to urge measures to enhance payment for primary care in the inner city.~~
12 (Modify Current HOD Policy)

Fiscal note: \$1,000.

APPENDIX A: PROPOSED AMA POLICY: “PRINCIPLES OF AND ACTIONS TO ADDRESS PRIMARY CARE WORKFORCE” (WORKSHEET VERSION)

Note: The left column shows the proposed language for adoption ; the right column shows the original language that is being modified and its policy number, if any.

Proposed language for adoption	Original language
1. Our patients require a sufficient, well-trained supply of primary care physicians—family physicians, general internists, general pediatricians, and obstetricians/gynecologists—to meet the nation’s current and projected demand for health care services.	The AMA believes that there should be a sufficient supply of primary care physicians - family physicians, general internists, general pediatricians, and obstetricians/gynecologists. In order to achieve this objective: H-200.997
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).	(new)
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components:	4. Our AMA will collaborate with appropriate organizations to support the development of innovative models to recruit medical students interested in primary care, to train primary care physicians, and to enhance the image of primary care practice. D-200.979
a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans;	(3) It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians and improved recruitment of medical school graduates into primary care specialties. H-200.997
b) Curriculum changes throughout the medical education continuum;	It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians, improved recruitment of medical school graduates and training a sufficient number of
c) Expanded financial aid and debt relief options;	
d) Financial and logistical support for primary care practice, including	

Proposed language for adoption	Original language
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.	primary care physicians to meet projected national needs. H-200.977 The AMA will continue to recommend specific strategies to increase the availability of primary care physicians, which may include curricular modification, financing mechanisms for medical education and research, financial aid options, and modifications of the practice environment. H-200.975 2. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including: a. admissions policies ...D-200.979
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.	(2) The admission process should be sensitive to the institution's mission. Those schools with missions that include primary care should consider those predictor variables known to be associated with choice of these specialties. H-200.973
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.	(3) Through early recruitment and outreach activities, attempts should be made to increase the pool of applicants likely to practice primary care. H-200.973 (11) Urge medical schools to seek out those students whose profiles indicate a likelihood of practicing in underserved urban areas, while establishing strict guidelines to preclude discrimination. H-200.972 (12) Encourage medical school outreach activities into secondary schools, colleges, and universities to stimulate students with these profiles to apply to medical school. H-200.972
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) Medical schools should provide career counseling related to the choice of a primary care specialty. H-200.973 5. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including: ... b. utilization of primary care physicians in the roles of

Proposed language for adoption	Original language
	teachers, mentors, and role models.... D-200.979
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.	Federal financial assistance programs aimed at stimulating interest in primary care should have the following characteristics: (1) Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities. H-200.966
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued, including such innovations as a three-year medical school curriculum that leads directly to primary care residency programs. The establishment of appropriate administrative units for family medicine should be encouraged.	(1) Voluntary efforts to develop and expand both undergraduate and graduate programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for family practice should be encouraged. H-200.997
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.	(4) Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. H-200.973
	(13) Encourage medical schools to continue to change their curriculum to put more emphasis on primary care. H-200.972
	(1) Each medical school should reexamine its institutional goals and objectives, including the extent of its commitment to primary care. Those schools recognizing a commitment related to primary care should make this an explicit part of the mission, and set institutional priorities accordingly. H-200.973
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.	(5) All four years of the curriculum in every medical school should provide experiences in primary care for all students. These experiences should feature increasing levels of student responsibility and use of ambulatory and community settings. H-200.973
	5. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including: ... c. educational

Proposed language for adoption	Original language
	experiences in community-based primary care settings. D-200.979
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.	(2) Federal support, without coercive terms, should be available to institutions needing financial support for the expansion of resources for both undergraduate and graduate programs designed to increase the number of primary care physicians. H-200.997
	7. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide graduate medical education for resident physicians and fellows in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. D-200.979
	8. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide undergraduate medical education for students in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. D-200.979
	Our AMA encourages the Bureau of Health Professions to establish a series of grants for innovative pilot programs that change the current approaches to medical education at the undergraduate/graduate level in the primary care area which can be evaluated for their effectiveness in increasing the number of students choosing primary care careers. H-295.956
	2. Our AMA will encourage the Centers for Medicare & Medicaid Services, American Osteopathic Association, Accreditation Council for Graduate Medical Education, American Board of Medical Specialties and the Association of American Medical Colleges to foster the development of innovative training programs for medical students, residents and fellows in rural and

Proposed language for adoption	Original language
	underserved areas so that the number of physicians increases in these underserved areas, which would facilitate the elimination of geographic, racial, and other health care disparities. H-200.982
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.	(3) Promote medical student rotations through the various inner-city neighborhood family health clinics, with financial assistance to the clinics to compensate their teaching efforts. H-200.972 (4) Encourage medical schools and teaching hospitals to integrate third- and fourth-year undergraduate medical education and residency training into these teams. H-200.972
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).	(8) The curriculum in primary care residency programs and the sites used for training should be consistent with the objective of training generalist physicians. H-200.973 Our AMA advocates that the Accreditation Council for Graduate Medical Education support primary care residency programs, including community hospital based programs. H-310.973 6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) to develop an accreditation environment and novel pathways that promote innovations in training that use progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model. D-200.979
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.	(6) The visibility of primary care faculty members should be enhanced within the medical school and positive attitudes toward primary care among all faculty members should be encouraged. H-200.973
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure	(10) Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, and enhanced efforts to eliminate “hassle” and unnecessary paper work should be undertaken. H-200.973

Proposed language for adoption	Original language
professional satisfaction and practice sustainability.	
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.	(9) There should be increased financial incentives for physicians practicing primary care. H-200.973
	1. Our AMA encourages state legislatures and the Congress of the United States to recognize this significant problem and to develop rapidly incentives to make practice in rural and urban underserved areas more attractive to primary care physicians in order to provide access to necessary medical services in these areas. H-200.982
	(18) Continue to urge measures to enhance payment for primary care in the inner city. H-200.972
	(14) Urge state medical associations to support the development of methods to improve physician compensation for serving this population, such as Medicaid case management programs in their respective states. H-200.972
	2. Our AMA supports existing programs and advocate for the introduction of new programs in the public and private sectors that decrease the debt load of physicians who choose to practice in a primary care specialty. D-200.979
	The AMA will (1) work with federal and state governments to develop incentive programs, such as loan repayment, to encourage practice in underserved areas, H-200.978
	(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. H-200.973
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and	1. In collaboration with relevant specialty societies, our AMA will take the following actions related to reimbursement for primary care physician services: a. Continue to advocate for the recommendations from the AMA/Specialty Society RVS Update

Proposed language for adoption	Original language
coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.	Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions. b. Work to assure that private payers fully recognize the value of E&M services, incorporating the RUC recommended increases adopted for the most current Medicare RBRVS. D-200.979
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.	9. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919. D-200.979
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.	(11) There should be educational support systems for primary care physicians, especially those practicing in underserved areas. H-200.973
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.	(17) Urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities. H-200.972
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.	(16) Urge CMS to explore the use of video and computer capabilities to improve access to and support for urban primary care practices in underserved settings. H-200.972
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.	The AMA urges accredited continuing medical education sponsors to promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services. H-300.957
23. Practicing physicians in other specialties—particularly those practicing in underserved urban or rural areas—should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition,	(7) Consider expanding opportunities for practicing physicians in other specialties to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family practice, internal medicine, pediatrics, etc. These may be developed so that they are part-time, thereby allowing physicians enrolling in these programs to practice concurrently. H-200.972

Proposed language for adoption	Original language
part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.	(6) Study the concept of having medical schools with active outreach programs in the inner city offer additional training to physicians from nonprimary care specialties who are interested in achieving specific primary care competencies. H-200.972
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.	Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747. H-200.956
	Our AMA will encourage members to communicate with their US Senators and Representatives to support Public Health Service Act, Title VII, Section 747. D-200.994
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.	Federal financial assistance programs aimed at stimulating interest in primary care should have the following characteristics:... (2) There should be an analysis of outcome data for federal financial assistance programs, to determine if they are having the desired effects and a study of the impact of these programs on disadvantaged and underrepresented groups of students. H-200.966
	(2) engage in research to identify all factors which deter students and physicians from choosing and remaining in primary care disciplines H-200.978
	3. Our AMA will continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. D-200.979
	and (3) use this information to support and implement AMA policy to enhance primary care as a career choice. H-200.978

APPENDIX B: PROPOSED AMA POLICY: “PRINCIPLES OF AND ACTIONS TO ADDRESS PRIMARY CARE WORKFORCE” (TEXT VERSION)

1. Our patients require a sufficient, well-trained supply of primary care physicians—family physicians, general internists, general pediatricians, and obstetricians/gynecologists—to meet the nation’s current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components:
 - a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans;
 - b) Curriculum changes throughout the medical education continuum;
 - c) Expanded financial aid and debt relief options;
 - d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and
 - e) Support for research and advocacy related to primary care.
4. **Admissions and recruitment:** The medical school admissions process should reflect the specific institution’s mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. **Career counseling and exposure to primary care:** Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. **Curriculum:** Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued, including such innovations as a three-year medical school curriculum that leads

directly to primary care residency programs. The establishment of appropriate administrative units for family medicine should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. **Support for practicing primary care physicians:** Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and

decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties—particularly those practicing in underserved urban or rural areas—should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. **Research:** Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

APPENDIX C: AMA POLICIES AND DIRECTIVES PROPOSED FOR RESCISSION

1. *D-200.979, “Barriers to Primary Care as a Medical School Choice”*

1. In collaboration with relevant specialty societies, our AMA will take the following actions related to reimbursement for primary care physician services: a. Continue to advocate for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions. b. Work to assure that private payers fully recognize the value of E&M services, incorporating the RUC recommended increases adopted for the most current Medicare RBRVS.
2. Our AMA supports existing programs and advocate for the introduction of new programs in the public and private sectors that decrease the debt load of physicians who choose to practice in a primary care specialty.
3. Our AMA will continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions.
4. Our AMA will collaborate with appropriate organizations to support the development of innovative models to recruit medical students interested in primary care, to train primary care physicians, and to enhance the image of primary care practice.
5. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including: a. admissions policies b. utilization of primary care physicians in the roles of teachers, mentors, and role models, and c. educational experiences in community-based primary care settings.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) to develop an accreditation environment and novel pathways that promote innovations in training that use progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model.
7. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide graduate medical education for resident physicians and fellows in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice.
8. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide undergraduate medical education for students in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice.
9. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

CME Rep. 3, I-08; Appended: CME Rep. 8, A-10; Modified: CCB/CLRPD Rep. 2, A-14

2. *D-200.994, “Appropriations for Increasing Number of Primary Care Physicians”*

Our AMA will encourage members to communicate with their US Senators and Representatives to support Public Health Service Act, Title VII, Section 747.

Res. 814, I-03; Reaffirmed: BOT Rep. 28, A-13

3. *H-200.956, "Appropriations for Increasing Number of Primary Care Physicians"*

Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747. Res. 814, I-03; Reaffirmation I-08

4. *H-200.966, "Federal Financial Incentives and Medical Student Career Choice"*

To further expand policy the AMA has adopted the following:

Federal financial assistance programs aimed at stimulating interest in primary care should have the following characteristics:

(1) Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

(2) There should be an analysis of outcome data for federal financial assistance programs, to determine if they are having the desired effects and a study of the impact of these programs on disadvantaged and underrepresented groups of students.

CME Rep. 6, A-94; Reaffirmed: CME Rep. 2, A-05; Modified: CME Rep. 13, A-06; Reaffirmation I-08

5. *H-200.973, "Increasing the Availability of Primary Care Physicians"*

It is the policy of the AMA that:

(1) Each medical school should reexamine its institutional goals and objectives, including the extent of its commitment to primary care. Those schools recognizing a commitment related to primary care should make this an explicit part of the mission, and set institutional priorities accordingly.

(2) The admission process should be sensitive to the institution's mission. Those schools with missions that include primary care should consider those predictor variables known to be associated with choice of these specialties.

(3) Through early recruitment and outreach activities, attempts should be made to increase the pool of applicants likely to practice primary care.

(4) Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective.

(5) All four years of the curriculum in every medical school should provide experiences in primary care for all students. These experiences should feature increasing levels of student responsibility and use of ambulatory and community settings.

(6) The visibility of primary care faculty members should be enhanced within the medical school and positive attitudes toward primary care among all faculty members should be encouraged.

(7) Medical schools should provide career counseling related to the choice of a primary care specialty.

(8) The curriculum in primary care residency programs and the sites used for training should be consistent with the objective of training generalist physicians.

(9) There should be increased financial incentives for physicians practicing primary care.

(10) Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, and enhanced efforts to eliminate "hassle" and unnecessary paper work should be undertaken.

(11) There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

(12) States should be encouraged to provide positive incentives--such as scholarship or loan repayment programs, relief of professional liability burdens and reduction of duplicative administrative responsibilities--to support medical students' choice of a primary care specialty. The

imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

CME Rep. N, A-93; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 13, A-06; Reaffirmed: CME Rep. 1, I-08; Reaffirmation I-08

6. *H-200.975, "Availability, Distribution and Need for Family Physicians"*

The AMA will continue to recommend specific strategies to increase the availability of primary care physicians, which may include curricular modification, financing mechanisms for medical education and research, financial aid options, and modifications of the practice environment. Sub. Res. 306, I-92; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, I-03; Reaffirmation I-08

7. *H-200.977, "Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians"*

It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians, improved recruitment of medical school graduates and training a sufficient number of primary care physicians to meet projected national needs.

Res. 306, I-91; Reaffirmed: BOT Rep. GG, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmation I-08

8. *H-200.978, "Loan Repayment Programs for Primary Care Careers"*

The AMA will (1) work with federal and state governments to develop incentive programs, such as loan repayment, to encourage practice in underserved areas, (2) engage in research to identify all factors which deter students and physicians from choosing and remaining in primary care disciplines and (3) use this information to support and implement AMA policy to enhance primary care as a career choice.

BOT Rep. EEE, A-91; Reaffirmed: BOT Rep. GG, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmation I-06; Reaffirmed: CME Rep. 1, I-08

9. *H-200.982, "Significant Problem of Access to Health Care in Rural and Urban Underserved Areas"*

1. Our AMA encourages state legislatures and the Congress of the United States to recognize this significant problem and to develop rapidly incentives to make practice in rural and urban underserved areas more attractive to primary care physicians in order to provide access to necessary medical services in these areas.

2. Our AMA will encourage the Centers for Medicare & Medicaid Services, American Osteopathic Association, Accreditation Council for Graduate Medical Education, American Board of Medical Specialties and the Association of American Medical Colleges to foster the development of innovative training programs for medical students, residents and fellows in rural and underserved areas so that the number of physicians increases in these underserved areas, which would facilitate the elimination of geographic, racial, and other health care disparities.

Sub. Res. 35, I-90; Reaffirmed: BOT Rep. GG, I-92; Reaffirmation A-01; Modified: CME Rep. 2, I-03; Appended: Res. 320, A-10

10. H-200.997, "Primary Care"

The AMA believes that there should be a sufficient supply of primary care physicians - family physicians, general internists, general pediatricians, and obstetricians/gynecologists. In order to achieve this objective:

(1) Voluntary efforts to develop and expand both undergraduate and graduate programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for family practice should be encouraged.

(2) Federal support, without coercive terms, should be available to institutions needing financial support for the expansion of resources for both undergraduate and graduate programs designed to increase the number of primary care physicians.

(3) It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians and improved recruitment of medical school graduates into primary care specialties.

CME Rep. C, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: BOT Rep. GG, I-92;
Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, I-03; Reaffirmation I-08

11. H-295.956, "Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers"

Our AMA encourages the Bureau of Health Professions to establish a series of grants for innovative pilot programs that change the current approaches to medical education at the undergraduate/graduate level in the primary care area which can be evaluated for their effectiveness in increasing the number of students choosing primary care careers.

Res. 173, I-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10

12. H-300.957, "Promoting Primary Care Services Through Continuing Medical Education"

The AMA urges accredited continuing medical education sponsors to promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

Res. 311, A-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14

13. H-310.973, "Primary Care Residencies in Community Hospitals"

Our AMA advocates that the Accreditation Council for Graduate Medical Education support primary care residency programs, including community hospital based programs.

Sub. Res. 27, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-08

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-I-18

Subject: Reconciliation of AMA Policy on Resident/Fellow Contracts and Duty Hours

Presented by: Carol Berkowitz, MD, Chair

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

INTRODUCTION

The goal of this report is to review, reconcile, and consolidate existing American Medical Association (AMA) policy on resident/fellow contracts and duty hours, eliminate duplication, and ensure that current policies are coherent and relevant. For each policy recommendation, a succinct but cogent justification is provided to support the proposed action. The most recent policy was deemed to supersede contradictory past AMA policies, and the language of each proposed policy was edited so that it is coherent and easily understood, without altering its meaning or intent.

POLICIES INCLUDED IN THIS REPORT

The following AMA policies are addressed in this report:

1. D-310.987, "Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety"
2. H-310.907, "AMA Duty Hours Policy"
3. H-310.912, "Residents and Fellows' Bill of Rights"
4. H-310.922, "Determining Residents' Salaries"
5. H-310.929, "Principles for Graduate Medical Education"
6. H-310.932, "Annual Contracts for Continuing Residents"
7. H-310.947, "Revision of the 'General Requirements' of the Essentials of Accredited Residency Programs"
8. H-310.979, "Resident Physician Working Hours and Supervision"
9. H-310.988, "Adequate Resident Compensation"
10. H-310.999, "Guidelines for Housestaff Contracts or Agreements"

SUMMARY AND RECOMMENDATIONS

This report encompasses a review of current AMA policies on resident/fellow contracts and duty hours to ensure such policy is consistent, accurate, and up-to-date. Three of the 10 policies being addressed in this report are recommended for revision, as shown in Appendix A, with a clean text version shown in Appendix B:

- H-310.907, "AMA Duty Hours Policy"
- H-310.912, "Residents and Fellows' Bill of Rights"
- H-310.929, "Principles for Graduate Medical Education"

Appendix C lists the seven remaining policies that are proposed for rescission. Relevant aspects of the following four of these seven policies are recommended for a) incorporation into the three policies above and b) rescission:

- D-310.987, “Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety”
- H-310.922, “Determining Residents’ Salaries”
- H-310.947, “Revision of the ‘General Requirements’ of the Essentials of Accredited Residency Programs”
- H-310.979, “Resident Physician Working Hours and Supervision”

The remaining three policies being treated in this report are recommended for rescission and are not being retained in the three revised policies, as they are superseded by or already reflected in existing AMA policy:

- H-310.932, “Annual Contracts for Continuing Residents”
- H-310.988, “Adequate Resident Compensation”
- H-310.999, “Guidelines for Housestaff Contracts or Agreements”

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

1. That our American Medical Association (AMA) adopt the proposed revisions shown in Appendix A, column 1, for the following three policies:

- 1) H-310.907, “AMA Duty Hours Policy” (with revised title: “Resident/Fellow Clinical and Educational Work Hours”)
- 2) H-310.912, “Residents and Fellows’ Bill of Rights”
- 3) H-310.929, “Principles for Graduate Medical Education”
(Modify Current HOD Policy)

2. That our AMA rescind the following seven policies, as shown in Appendix C, and incorporate relevant portions of four of these policies into existing AMA policy:

- 1) D-310.987, “Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety”
- 2) H-310.922, “Determining Residents’ Salaries”
- 3) H-310.932, “Annual Contracts for Continuing Residents”
- 4) H-310.947, “Revision of the ‘General Requirements’ of the Essentials of Accredited Residency Programs”
- 5) H-310.979, “Resident Physician Working Hours and Supervision”
- 6) H-310.988, “Adequate Resident Compensation”
- 7) H-310.999, “Guidelines for Housestaff Contracts or Agreements”
(Rescind HOD Policy)

Fiscal note: \$1,000.

APPENDIX A: PROPOSED REVISIONS TO THREE AMA POLICIES RELATED TO
RESIDENT/FELLOW CONTRACTS AND DUTY HOURS (WORKSHEET VERSION)

Note: The right column shows the original language; the left column shows the recommended action and any edits to the original language.

H-310.907, “AMA duty hours policy”

Proposed language for adoption	Original language
<i>Note: Revise title of policy and aspects of policy as noted below, to reflect 2018 terminology from the Accreditation Council for Graduate Medical Education (ACGME), with “duty hours” replaced by “clinical and educational work hours.”</i>	
Policy Title: ~~AMA duty hours policy~~ <u>Resident/Fellow Clinical and Educational Work Hours</u>	Policy Title: AMA duty hours policy
Our AMA adopts the following Principles of Resident/Fellow ~~Duty Hours~~ <u>Clinical and Educational Work Hours</u> , Patient Safety, and Quality of Physician Training:”	Our AMA adopts the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training:
1. Our AMA ~~reaffirms~~ supports of the 2003 <u>2017</u> Accreditation Council for Graduate Medical Education (ACGME) ~~duty hour~~ standards <u>for clinical and educational work hours (previously referred to as “duty hours”)</u> .	1. Our AMA reaffirms support of the 2003 Accreditation Council for Graduate Medical Education (ACGME) duty hour standards. <i>(Note: The 2003 standards have been superseded by the 2017 standards.)</i>
2. Our AMA will continue to monitor the enforcement and impact of ~~duty~~ <u>clinical and educational work</u> hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.	2. Our AMA will continue to monitor the enforcement and impact of duty hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of ~~duty~~ <u>clinical and educational work</u> hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.	3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of ~~duty~~ <u>clinical and educational work</u> hour requirements and, pending the outcomes of	4. Our AMA endorses the study of innovative models of duty hour requirements and, pending the outcomes of ongoing and future research,

Proposed language for adoption	Original language
ongoing and future research, should consider the evolution of specialty- and rotation-specific ~~duty~~ hours requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.	should consider the evolution of specialty- and rotation-specific duty hours requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:	<i>(unchanged)</i>
a) Decrease the barriers to reporting of both ~~duty~~ <u>clinical and educational work</u> hour violations and resident intimidation.	a) Decrease the barriers to reporting of both duty hour violations and resident intimidation.
b) Ensure that readily accessible, timely and accurate information about ~~duty~~ <u>clinical and educational work</u> hours is not constrained by the cycle of ACGME survey visits.	b) Ensure that readily accessible, timely and accurate information about duty hours is not constrained by the cycle of ACGME survey visits.
c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of ~~resident-duty~~ <u>clinical and educational work</u> hour rules.	c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of resident duty hour rules.
d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of ~~duty~~ <u>clinical and educational work</u> hours.	d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of duty hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:	<i>(unchanged)</i>
a) Offer incentives to programs/institutions to ensure compliance with ~~duty~~ <u>clinical and educational work</u> hour standards.	a) Offer incentives to programs/institutions to ensure compliance with duty hour standards.
b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.	<i>(unchanged)</i>
c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.	<i>(unchanged)</i>
d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.	<i>(unchanged)</i>
7. Our AMA supports the following statements related to ~~duty~~ <u>clinical and educational work</u> hours:	7. Our AMA supports the following statements related to duty hours:
a) ~~Resident physician~~ <u>Total duty clinical and educational work</u> hours must not exceed 80	a) Resident physician total duty hours must not exceed 80 hours per week, averaged over a four-

Proposed language for adoption	Original language
hours per week, averaged over a four-week period (Note: “Total <u>duty clinical and educational work</u> hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).	week period (Note: “Total duty hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.	<i>(unchanged)</i>
c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.	<i>(unchanged)</i>
d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.	<i>(unchanged)</i>
e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”	<i>(unchanged)</i>
f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, <u>duty clinical and educational work</u> hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, to the 16-hour shift limit for first-year residents, or allowing a limited increase to the total number of <u>duty clinical and educational work</u> hours when need is demonstrated.	f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, duty hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, to the 16-hour shift limit for first-year residents, or allowing a limited increase to the total number of duty hours when need is demonstrated.

Proposed language for adoption	Original language
g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.	<i>(unchanged)</i>
h) ~~Duty~~ <u>Clinical and educational work</u> hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total ~~duty~~ <u>clinical and educational work</u> hour limits for all resident physicians.	h) Duty hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total duty hour limits for all resident physicians.
i) Scheduled time providing patient care services of limited or no educational value should be minimized.	<i>(unchanged)</i>
j) Accurate, honest, and complete reporting of ~~resident duty~~ <u>clinical and educational work</u> hours is an essential element of medical professionalism and ethics.	j) Accurate, honest, and complete reporting of resident duty hours is an essential element of medical professionalism and ethics.
k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of ~~duty~~ <u>clinical and educational work</u> hour regulations, and opposes any regulatory or legislative proposals to limit the ~~duty work~~ hours of practicing physicians.	k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of duty hour regulations, and opposes any regulatory or legislative proposals to limit the duty hours of practicing physicians.
l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.	<i>(unchanged)</i>
m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.	<i>(unchanged)</i>
n) The costs of ~~duty~~ <u>clinical and educational work</u> hour limits should be borne by all health	n) The costs of duty hour limits should be borne by all health care payers.

Proposed language for adoption	Original language
care payers. <u>Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.</u>	(j) Individual resident compensation and benefits must not be compromised or decreased as a result of these recommended changes in the graduate medical education system. H-310.979
o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.	(unchanged)
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.	(unchanged)
<u>9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians.</u>	Our American Medical Association will actively participate in ongoing efforts to monitor the impact of resident duty hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians. D-310.987
CME Rep. 5, A-14	

H-310.912, “Residents and Fellows’ Bill of Rights”

Proposed language for adoption	Original language
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.	(unchanged)
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.	(unchanged)
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this Residents and Fellow Physicians’ Bill of Rights.	3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this Residents and Fellows’ Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution’s process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or	(unchanged)

Proposed language for adoption	Original language
within one month of document submission is strongly recommended.	
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.	<i>(unchanged)</i>
6. Our AMA adopts the following ‘Residents and Fellows’ Bill of Rights’ as applicable to all resident and fellow physicians in ACGME-accredited training programs:	<i>(unchanged)</i>
~~RESIDENTS AND FELLOW PHYSICIANSs’~~ BILL OF RIGHTS	RESIDENTS AND FELLOWS’ BILL OF RIGHTS
Residents and fellows have a right to:	<i>(unchanged)</i>
A. An education that fosters professional development, takes priority over service, and leads to independent practice.	<i>(unchanged)</i>
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.	<i>(unchanged)</i>
B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.	<i>(unchanged)</i>
With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience.	With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience.

Proposed language for adoption	Original language
<u>It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.</u>	(i) Is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. As stated in the ACGME Common Program Requirements (VI.B) “the program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.” H-310.979
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.	<i>(unchanged)</i>
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.	<i>(unchanged)</i>
D. A safe and supportive workplace with appropriate facilities.	<i>(unchanged)</i>
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.	<i>(unchanged)</i>
E. Adequate compensation and benefits that provide for resident well-being and health.	<i>(unchanged)</i>
(1) With regard to contracts, residents and fellows should receive: a. Information about the	<i>(unchanged)</i>

Proposed language for adoption	Original language
interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.	
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience; <u>Compensation should and that reflect cost of living differences based on geographical differences; local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.</u>	(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience, and that reflect cost of living differences based on geographical differences. 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. H-310.922
(3) With Regard to Benefits, Residents and Fellows <u>Must Be Fully Informed of and Should Receive:</u> a. Quality and affordable comprehensive medical, mental health, dental, and vision care <u>for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program;</u> b. <u>An institutional written policy on and e</u>Education ~~on~~ <u>in</u> the signs of excessive fatigue, clinical depression, ~~and~~ substance abuse and dependence, <u>and other physician impairment issues;</u> c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined	(3) With Regard to Benefits, Residents and Fellows Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care; b. Education on the signs of excessive fatigue, clinical depression, and substance abuse and dependence; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and paternity leave and educational leave during each year in their training program the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act.

Proposed language for adoption	Original language
amount of paid vacation leave, sick leave, ~~maternity and paternity~~ family and medical leave and educational/<u>professional</u> leave during each year in their training program, the total amount of which should not be less than six weeks; ~~and e. Leave in compliance with the Family and Medical Leave Act-;~~ <u>and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.</u>	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
F. ~~Duty~~ <u>Clinical and educational work</u> hours that protect patient safety and facilitate resident well-being and education.	F. Duty hours that protect patient safety and facilitate resident well-being and education.
With regard to ~~duty~~ <u>clinical and educational work</u> hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with ~~duty-clinical and educational work~~ hour requirements set forth by the ACGME ~~or other relevant accrediting body~~; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that ~~duty-clinical and educational work~~ hour requirements are effectively circumvented. <u>Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.</u>	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.	(unchanged)
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)

Proposed language for adoption	Original language
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.	<i>(unchanged)</i>
CME Rep. 8, A-11 Appended: Res. 303, A-14 Reaffirmed: Res. 915, I-15 Appended: CME Rep. 04, A-16	

H-310.929, “Principles for Graduate Medical Education”

Proposed language for adoption	Original language
Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in ~~the revised “its Institutional Requirements” of the Essentials of Accredited Residencies of Graduate Medical Education~~ , if they are not already present.	Our AMA urges the Accreditation Council for Graduate Medical Education to incorporate these principles in the revised “Institutional Requirements” of the Essentials of Accredited Residencies of Graduate Medical Education, if they are not already present.
(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. <u>Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program’s educational objectives for the residents.</u>	(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. H-310.979
(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.	(unchanged)
(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.	(unchanged)
(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities	(unchanged)

Proposed language for adoption	Original language
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.	<i>(unchanged)</i>
(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the ~~Essentials for Accredited Residencies in Graduate Medical Education~~ <u>accreditation requirements of the ACGME</u>, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow	(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or

Proposed language for adoption	Original language
residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.	similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.
(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.	<i>(unchanged)</i>
(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the “Program Requirements.” The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician’s education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.	<i>(unchanged)</i>
(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.	<i>(unchanged)</i>
(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and	<i>(unchanged)</i>

Proposed language for adoption	Original language
information systems, and population-based medicine should be included as appropriate to the specialty.	
(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.	<i>(unchanged)</i>
(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise <u>and evaluate</u> the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, <u>and specified in the ACGME Institutional Requirements and related accreditation documents,</u> must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician <u>and the level of responsibility for the care of patients that may be safely delegated to the resident.</u> <u>The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible</u>	(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows.

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<u>for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards.</u> Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. <u>Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.</u>	(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. (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. (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. (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. H-310.979
(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board	(unchanged)

Proposed language for adoption	Original language
certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.	
(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.	(unchanged)
(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.	(unchanged)
CME Rep. 9, A-99 Reaffirmed: CME Rep. 2, A-09 Reaffirmed: CME Rep. 14, A-09	

APPENDIX B: PROPOSED REVISIONS TO THREE AMA POLICIES RELATED TO
RESIDENT/FELLOW CONTRACTS AND DUTY HOURS (CLEAN TEXT VERSION)

H-310.907, “Resident/Fellow Clinical and Educational Work Hours”

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:”

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as “duty hours”).
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
 - a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
 - b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
 - c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
 - d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
 - a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.

- b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
 - c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
 - d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
- a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: “Total clinical and educational work hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
 - b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.
 - c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
 - d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
 - e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”
 - f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
 - g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.

- h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
 - i) Scheduled time providing patient care services of limited or no educational value should be minimized.
 - j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
 - k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.
 - l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
 - m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
 - n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.
 - o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.
8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.
9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

H-310.912, “Residents and Fellows’ Bill of Rights”

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians’ Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution’s process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.
6. Our AMA adopts the following ‘Residents and Fellows’ Bill of Rights’ as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS’ BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that

minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

H-310.929, "Principles for Graduate Medical Education"

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.

(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.

(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the

affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) **COMPENSATION OF RESIDENT PHYSICIANS.** All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) **LENGTH OF TRAINING.** The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) **PROVISION OF FORMAL EDUCATIONAL EXPERIENCES.** Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) **INNOVATION OF GRADUATE MEDICAL EDUCATION.** The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) **THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION.** Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) **SUPERVISION OF RESIDENT PHYSICIANS.** Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the

ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

APPENDIX C: AMA POLICIES AND DIRECTIVES PROPOSED FOR RESCISSION

Note: The following seven policies are recommended for rescission. The original language is shown in the left column; the rationale for rescission is in the right column.

D-310.987, “Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety”

Original language	Rationale for rescission
Our American Medical Association will actively participate in ongoing efforts to monitor the impact of resident duty hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians.	Still relevant, but rescind and append to H-310.907 (9), “AMA duty hours policy.”
Res. 314, A-03 Reaffirmation A-12	

H-310.922, “Determining Residents’ Salaries”

Original language	Rationale for rescission
Our AMA encourages teaching institutions to base residents’ salaries on the resident’s level of training as well as local economic factors, such as housing, transportation, and energy costs, that affect the purchasing power of wages, with appropriate adjustments for changes in cost of living.	Still relevant, but rescind and incorporate into H-310.912 (E.2), “Residents and Fellows’ Bill of Rights.”
Res. 303, A-06 Modified: CME Rep. 04, A-16	

H-310.932, “Annual Contracts for Continuing Residents”

Original language	Rationale for rescission
Our AMA urges the ACGME to require resident training programs to provide their residents with notice of non-renewal of contracts no later than four months prior to the end of their contract.	Still relevant, but rescind; already reflected in H-310.912 (E), “Residents and Fellows’ Bill of Rights,” as follows: “(1) With regard to contracts, residents and fellows should receive: ... b. At least four months advance notice of contract non-renewal and the reason for non-renewal.”
Sub. Res. 310, A-99 Reaffirmed: CME Rep. 2, A-09	

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

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

vacations, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance, and other insurance benefits for the residents and their family and the conditions under which living quarters, meals and laundry or their equivalent are to be provided. Institutions sponsoring graduate medical education must provide access to insurance, where available, to all residents for disabilities resulting from activities that are part of the educational program. Institutions should have a written policy and an educational program regarding physician impairment, including substance abuse.	Note: This policy is also reflected in ACGME Institution Requirements, effective July 1, 2018, under IV.A.3., III.B.7.b), and IV.B.
CME Rep. Q, A-93 Modified: CME Rep. 2, A-03 Reaffirmed: CME Rep. 2, A-13	

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

Original language	Rationale for rescission
(1) Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress:	Still relevant, but rescind and incorporate relevant aspects into other policies, as noted below.
(a) Exemplary patient care is a vital component for any program of graduate medical education. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited residency program. Graduate medical education must never compromise the quality of patient care.	Incorporate into H-310.929 (1), “Principles for Graduate Medical Education.”
(b) Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program’s educational objectives for the residents.	

Original language	Rationale for rescission
(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. (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. (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. (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.	Incorporate relevant aspects into H-310.929 (12), "Principles for Graduate Medical Education."
(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

Original language	Rationale for rescission
	external site, or through telemedicine or other virtual, online means.”
(h) As stated in the ACGME Institutional Requirements (II.F.2.a-c), “The Sponsoring Institution must provide services and develop health care delivery systems to minimize residents’ work that is extraneous to their GME programs’ educational goals and objectives.” These include patient support services, laboratory/pathology/radiology services, and medical records.	Rescind; already reflected in H-310.912 (A), “Residents and Fellows’ Bill of Rights,” as follows: “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: “i) Scheduled time providing patient care services of limited or no educational value should be minimized.”
(i) Is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. As stated in the ACGME Common Program Requirements (VI.B) “the program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.”	Incorporate into H-310.912 (B), “Residents and Fellows’ Bill of Rights.”
(j) Individual resident compensation and benefits must not be compromised or decreased as a result of these recommended changes in the graduate medical education system.	Incorporate into H-310.907 (7.n), “AMA duty hours policy.”
(2) These problems should be addressed within the present system of graduate medical education, without regulation by agencies of government.	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 & 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.”
CME Rep. C, I-87; Modified: Sunset Report, I-97; Modified and Reaffirmed: CME Rep. 2, A-08	

H-310.988, “Adequate Resident Compensation”

Original language	Rationale for rescission
The AMA believes that housestaff should receive adequate compensation by their training programs.	Still relevant, but rescind; already reflected in H-310.912 (E.2), “Residents and Fellows’ Bill of Rights,” and H-310.929 (7), “Principles for Graduate Medical Education.”
Sub. Res. 124, A-85 Reaffirmed by CLRPD Rep. 2, I-95 Reaffirmed: CME Rep. 2, A-05 Reaffirmed: CME Rep. 1, A-15	

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

Original language	Rationale for rescission
The “Essentials of Approved Residencies, “ approved by the House of Delegates in 1970, includes a section on relationships of housestaff and institutions. The following outline is intended to promote additional guidance to all parties in establishing the conditions under which house officers learn and provide services to patients.	Rescind; superseded by more recent AMA policy, including H-310.929, “Principles for Graduate Medical Education,” H-310.912, “Residents and Fellows’ Bill of Rights,” H-225.950, “AMA Principles for Physician Employment,” Code of Medical Ethics 9.2.4, “Disputes Between Medical Supervisors & Trainees,” H-225.942, “Physician and Medical Staff Member Bill of Rights,” along with the AMA Annotated Model Physician-Hospital Employment Agreement and AMA Annotated Model Physician-Group Practice Employment Agreement (see https://www.ama-assn.org/life-career/understanding-employment-contracts).
Training programs have been central to the process of graduate medical education which has produced a high level of medical competence in the United States. The American Medical Association recognizes that the integrity of these programs is a primary objective in achieving the best possible care of the patient. It is, therefore, incumbent upon members of the housestaff and the institutions in which they are being trained to be aware of the parameters and responsibilities applicable to their training programs. In the absence of such awareness, unreasonable expectations may arise to threaten the harmony between hospital and housestaff in the performance of their joint mission.	
It should be emphasized that these guidelines are not intended as a fixed formula. Guidelines that seek to cover public, voluntary and proprietary hospitals necessarily entail so many variables from training institution to training institution that no single form of contract or agreement would be universally applicable. This set of guidelines has, therefore, been developed to	

cover the more significant substantive provisions of a housestaff contract or agreement.	
The subjects included in the Guidelines are not intended to be the only subjects important or appropriate for a contract or agreement. Moreover, the definition of the respective responsibilities, rights and obligations of the parties involved can assume various forms: individual contracts or agreements, group contracts or agreements, or as a part of the rules of government of the institution.	
II. Proposed Terms and Conditions A. Parties to the Contract or Agreement (1) Contracts or agreements may be formed between individuals or groups, and institutions. Such a group might be a housestaff organization. (2) The two parties to an agreement or contract may be a single institution or a group of institutions, and an individual member of the housestaff, an informal group of the housestaff, or a formally constituted group or association of the housestaff, as determined by the housestaff organization.	
B. General Principles (1) Contracts or agreements are legal documents and must conform to the laws, rules, and regulation to which the institutions are subject. Position, salary and all other benefits should remain in effect insofar as possible without regard to rotational assignments even when the member of the housestaff is away from the parent institution. Exceptions required by law or regulations should be clearly delineated to the house officer at the time of the appointment. Changes in the number of positions in each year of a training program should be made so as not to affect adversely persons already in, or accepted in, that program. The agreement should provide fair and equitable conditions of employment for all those performing the duties of interns, residents and fellows. When a general contract or agreement is in effect between an association and an institution, individual contracts or agreements should be consistent. (2) Adequate prior notification of either party's intent not to review the contract or agreement should be required, and the date of such notification should be included in the contract or agreement. (3) The institution and the individual members of the housestaff must accept and recognize the right of the housestaff to determine the means by which the housestaff may organize its affairs, and both	

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	

procedure, a prior agreement as to how these costs will be apportioned between the parties.	
M. Disciplinary Hearings and Procedure With respect to disciplinary procedures, the provisions of Article VIII - Hearing and Appellate Review Procedure of the JCAHO Guidelines for the Formulation of Medical Staff Bylaws, Rules, and Regulations shall be applicable to the housestaff in the same manner as they are to all other members of the medical staff with the proviso that the Hearing and Appeals Committees shall contain appropriate representation of the housestaff.	
N. Description of the Educational Program The specific details of the operation of the educational experience should be made available to each prospective candidate. These data should include specific descriptions of training programs, including numbers of resident positions at each level of training, copies of existing housestaff contracts or agreements, approval status of programs to which candidate is applying, methods of evaluation, procedures for grievances and disciplinary action, and commitments for further training.	
O. Patient-Care Issues The quality of patient-care services and facilities may be specified in the contract, and could include such matters as adequate equipment, bedspace, clinical staffing, and clinical staff structuring.	
P. Other Provisions The agreement should provide for adequate, comfortable, safe, and sanitary facilities.	
The foregoing provisions are not all-inclusive. Depending upon the institution's size, resources, location, and affiliations, if any, and also depending upon the relationship between the institution and the housestaff association, other provisions may be included, such as: (1) Maintenance of existing benefits and practices not otherwise expressly covered; (2) Housing, meals, laundry, uniforms, living-out and telephone allowances; (3) Adequate office space, facilities, and supporting services for housestaff affairs; (4) Housestaff association seminars and meetings	
BOT Rep. H, I-74; Reaffirmed: CLRPD Rep. C, A-89; Appended: Res.323, I-97; Reaffirmation A-00; Reaffirmation A-08	

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 951
(I-18)

Introduced by: Resident and Fellow Section

Subject: Prevention of Physician and Medical Student Suicide

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

Whereas, The rate of suicide completion among medical professionals exceeds that of the combined U.S. population; and

Whereas, Suicides among physicians are perceived as isolated events¹; and

Whereas, Job stress is an independent risk factor for physician suicide²; and

Whereas, More understanding is needed about what systemic factors lead physicians to suicide; and

Whereas, Current AMA policy addresses a physician's or student's responsibility to seek mental health care, and encourages confidential reporting of risk factors by medical students, but does not include consequences for institutions that do not work to prevent suicide; and

Whereas, Work conditions beyond resident work hours, such as bullying, can contribute to suicide³; and

Whereas, Media coverage of physician suicide has increased dramatically in the past year; therefore be it

RESOLVED, That our American Medical Association request that the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education collect data on medical student, resident and fellow suicides to identify patterns that could predict such events.
(Directive to Take Action)

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

Received: 09/27/18

The topic of this resolution is currently under study by the Council on Medical Education.

References:

1 <https://www.fastcompany.com/3056015/thehiddenepidemicofdoctorsuicides>

2 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3549025/#idm140038005580816aff-infotitle>

3 <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0150246>

RELEVANT AMA POLICY**Access to Confidential Health Services for Medical Students and Physicians H-295.858**

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
 - A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
 - B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
 - C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
 - D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
 2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
 3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
 - A. be available to all medical students on an opt-out basis;
 - B. ensure anonymity, confidentiality, and protection from administrative action;
 - C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
 - D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
 4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
 5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
 6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
 7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
- Citation: CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 952
(I-18)

Introduced by: International Medical Graduates Section

Subject: IMG Section Member Representation on Committees/Task Forces/Councils

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

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.ecfm.org/about/leadership.html>

RELEVANT AMA POLICY

AMA Principles on International Medical Graduates H-255.988

Our AMA supports:

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.

3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

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

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

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

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

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

(BOT Rep. Z, A-86 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-13 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16 Appended: Res. 304, A-17 Modified: CME Rep. 01, I-17)

Visa Complications for IMGs in GME D-255.991

1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.

2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs' inability to complete accredited GME programs.

3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.

4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

(Res. 844, I-03 Reaffirmation A-09 Reaffirmation I-10 Appended: CME Rep. 10, A-11 Appended: Res. 323, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 953
(I-18)

Introduced by: Resident and Fellow Section

Subject: Support for the Income-Driven Repayment Plans

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

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) program¹⁻³; 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>

2 https://www.washingtonpost.com/news/grade-point/wp/2017/05/17/trump-and-devos-plan-to-reshape-higher-education-finance-heres-what-it-might-mean-for-you/?utm_term=.45d5f0a6d200

3 <https://www.cnn.com/2017/05/24/trumps-budget-seeks-to-cut-one-major-benefit-of-federal-student-loans.html>

RELEVANT AMA POLICY

H-305.965 Student Loans

Our AMA: (1) reaffirms its support of legislation that would defer the repayment of loans for education until the completion of residency training; and (2) will lobby for deferment of medical student loans for the full initial residency period. (Sub. Res. 203, A-90; Appended Res. 306, I-99; Reaffirmation A-01; Reaffirmation I-06; Modified: CME Rep 01, A-16)

Proposed Revisions to AMA Policy on Medical Student Debt D-305.970

Our AMA will:

1. Collaborate, based on AMA policy, with members of the Federation and the medical education community, and with other interested organizations, to achieve the following immediate public- and private-sector advocacy goals:

- (a) Support expansion of and adequate funding for federal scholarship and loan repayment programs, such as those from the National Health Service Corps, the Indian Health Service, the Armed Forces, and the Department of Veterans Affairs, and for comparable programs at the state level.
 - (b) Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
 - (c) With each reauthorization of the Higher Education Act and at every other legislative opportunity, proactively pursue loan consolidation terms that favor students and ensure that loan deferment is available for the entire duration of residency and fellowship training.
 - (d) Ensure that the Higher Education Act and other legislation allow interest from medical student loans to be fully tax deductible.
 - (e) Encourage medical schools, with the support of the Federation, to engage in fundraising activities devoted to increasing the availability of scholarship support.
 - (f) Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
 - (g) Support stable funding for medical education programs to limit excessive tuition increases.
2. Encourage medical schools to study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, combined baccalaureate/MD programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education. (CME Rep. 13, A-06; Reaffirmation I-08)

D-305.978 Mechanisms to Reduce Medical Student Debt

Our AMA will:

- (1) take an active advocacy role during the upcoming reauthorization of the Higher Education Act and other pending legislation, to achieve the following goals: (a) eliminating the single holder rule, (b) making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training, (c) retaining the option of loan forbearance for residents ineligible for loan deferment, (d) including, explicitly, dependent care expenses in the definition of the "cost of attendance," (e) including room and board expenses in the definition of tax-exempt scholarship income, (f) continuing the loan consolidation program, including the ability to "lock in" a fixed interest rate, and (g) adding the ability to refinance Federal Consolidation Loans;
- (2) continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases;
- (3) encourage members of the Federation to develop or enhance financial aid opportunities for medical students;
- (4) continue to monitor the availability of financial aid opportunities and financial planning/debt management counseling at medical schools, and share innovative approaches with the medical education community;
- (5) continue to collect and disseminate information to assist members of the Federation (state medical societies and specialty societies) and medical schools to establish or expand financial aid programs; and
- (6) continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students. (CME Rep. 10, A-04; Reaffirmation I-08)

D-305.980 Immediate Legislative Solutions to Medical Student Debt

Our AMA will: (1) endorse and actively lobby for the Reauthorization of the Higher Education Act, including: (a) Elimination of the "single-holder" rule; (b) Continuation of the consolidation loan program and a consolidator's ability to lock in a fixed interest rate; (c) Expansion of the deferment period for loan repayment to cover the entire duration of residency and fellowship; (d) Broadening of the definition of economic hardship as used to determine eligibility for student loan deferment; (e) Retention of the option of loan forbearance for residents who are ineligible for student loan deferment; and (f) Inclusion of dependent care expenses in the definition of "cost of attendance"; and

(2) lobby for passage of legislation that would: (a) Eliminate the cap on the student loan interest deduction; (b) Increase the income limits for taking the interest deduction; (c) Include room and board expenses in the definition of tax-exempt scholarship income; and (d) Make permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001. (Res. 850, I-03; Reaffirmation I-08)

D-305.984 Reduction in Student Loan Interest Rates

1. Our AMA will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.
3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.
4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.
5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training. (Res. 316, A-03; Reaffirmed: BOT Rep. 28, A-13; Appended: Res. 302, A-13; Modified and Appended: 301, A-16)

Medical School Financing, Tuition, and Student Debt D-305.993

1. The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of developing web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection, loan repayment programs, and a rotating loan program; and creating an AMA scholarship program funded through philanthropy. The AMA also should collect and disseminate information on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other purposes.
2. Our AMA will vigorously advocate for ongoing, adequate funding for federal and state programs that provide scholarship or loan repayment funds in return for service, including funding in return for practice in underserved areas, participation in the military, and participation in academic medicine or clinical research. Obtaining adequate support for the National Health Service Corps and similar programs, tied to the demand for participation in the programs, should be a focus for AMA advocacy efforts.
3. Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
4. Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students.
5. Our AMA supports a requirement that medical schools inform students of all government loan opportunities and requires disclosure of reasons that preferred lenders were chosen.
6. Our AMA will urge the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements to include a requirement that financial planning/debt management counseling be provided for resident physicians.
7. Our AMA will work with other organizations, including the Association of American Medical Colleges, residency program directors groups, and members of the Federation, to develop and disseminate standardized information, for example, computer-based modules, on financial planning/debt management for use by medical students, resident physicians, and young physicians.
8. Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of increasing loan deferment through the period of residency, promoting the expansion of subsidized loan programs, eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans.
9. Our AMA will advocate against putting a monetary cap on federal loan forgiveness programs.
10. Our AMA will: (a) advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; (b) work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be at least equal to the principal amount borrowed; and (c) ask the United States Department of Education to include all terms of Public Service Loan Forgiveness in the contractual obligations of the Master Promissory Note.
11. Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to require programs to include within the terms, conditions, and benefits of appointment to the program (which must be provided to applicants invited to interview, as per ACGME Institutional Requirements) information regarding the Public Service Loan Forgiveness (PSLF) program qualifying status of the employer.

12. Our AMA will advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility.

13. Our AMA encourages medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.

14. Our AMA encourages medical school financial advisors to promote to medical students service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.

15. Our AMA will strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

Citation: CME Rep. 2, I-00; Reaffirmation I-03; Reaffirmation I-06; Reaffirmation A-13; Appended: Res. 323, A-14; Appended: Res. 324, A-15; Appended: Res. 318, A-16; Appended: CME Rep. 07, A-17;

Modified: CME Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 954
(I-18)

Introduced by: American Academy of Dermatology, American Society for Dermatologic Surgery Association, American Society of Dermatopathology

Subject: VHA GME Funding

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

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 annually¹; and

Whereas, Resident physicians provide care directly to veterans and expand VHA's clinical capacity, allowing VHA patients to be seen more quickly¹; 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 delivery¹; and

Whereas, VHA is working to expand graduate medical education in primary care, mental health, and areas of physician shortages¹; 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^{1,2}; and

Whereas, Our American Medical Association supports GME expansion³; 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 programs⁴; 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)

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

Received: 09/28/18

¹ VA.gov

² https://aamc-black.global.ssl.fastly.net/production/media/filer_public/85/d7/85d7b689-f417-4ef0-97fb-ecc129836829/aamc_2018_workforce_projections_update_april_11_2018.pdf

³ The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

⁴ <https://www.stripes.com/news/mission-act-gets-funding-under-historically-high-va-budget-agreement-1.547070>

RELEVANT AMA POLICY

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap-setting deadline for new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates rates of placement into GME as well as GME completion.

33. Our AMA will investigate the status of implementation of AMA Policies D-305.973, Proposed Revisions to AMA Policy on the Financing of Medical Education Programs and D-305.967, The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education and report back to the House of Delegates with proposed measures to resolve the problems of underfunding, inadequate number of residencies and geographic maldistribution of residencies.

Sub. Res. 314, A-07 Reaffirmed: I-07 Reaffirmed: CME Rep. 4, I-08 Reaffirmed: Sub. Res. 314, A-09 Reaffirmed: CME Rep. 3, I-09 Reaffirmed: A-11 Appended: Res. 910, I-11 Reaffirmed in lieu of Res. 303, A-12 Reaffirmed in lieu of Res. 324, A-12 Reaffirmed: I-12 Reaffirmed: A-13 Appended: Res. 320, A-13 Appended: CME Rep. 5, A-13 Appended: CME Rep. 7, A-14 Appended: Res. 304, A-14 Modified: CME Rep. 9, A-15 Appended: CME Rep. 1, I-15 Appended: Res. 902, I-15 Reaffirmed: CME Rep. 3, A-16 Appended: Res. 320, A-16 Appended: CME Rep. 04, A-16 Appended: CME Rep. 05, A-16 Reaffirmed: A-16 Appended: Res. 323, A-17 Appended: CME Rep. 03, A-18 Appended: Res. 319, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 955
(I-18)

Introduced by: Medical Student Section

Subject: Equality for COMLEX and USMLE

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

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;^{2,4-5} 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;⁸⁻⁹⁵ and

1 Whereas, As an examination constructed to assess the basic science knowledge of allopathic
2 medical students, the NBME-CBSE is effective at predicting performance on COMLEX-USA
3 Level 1 for osteopathic medical students, implying that the same basic science knowledge is
4 expected for DO and MD students;⁹⁶ and
5

6 Whereas, A recent study of 795 students from three osteopathic medical schools who took both
7 USMLE Step 1 and COMLEX Level 1 found that scores were statistically significant across all
8 three schools and that there was "a strong association between COMLEX Level 1 and USMLE
9 Step 1 performance";⁹⁷ and
10

11 Whereas, A formula exists to convert COMLEX Level 1 and USMLE Step 1 scores, however,
12 research has shown that attempts to derive a USMLE score from a COMLEX score using the
13 Slocum and Louder formula predicted lower scores by an average of 14.16 points (6.8%), and
14 cautioned residency program directors from using such conversion methods;⁹⁸ and
15

16 Whereas, Dr. Jon Gimpel, President of the NBOME, stated that "because of the different
17 natures of the examinations, it is not possible—or even desirable—to make a direct numerical
18 comparison between the scores of the COMLEX-USA examination series and those of the
19 USMLE. When it comes to the examinations, the NBOME encourages residency program
20 directors to consider the COMLEX-USA series as the valid and most appropriate assessment
21 tool for osteopathic medical students. Our goal is to increase program directors' understanding
22 of the COMLEX-USA examination series, including its content, development, validity, and
23 scoring";⁹⁹ and
24

25 Whereas, "The single GME accreditation system is not expected to reduce acceptance of the
26 COMLEX-USA for residency admissions, but rather to continue to grow acceptance with the
27 goal of one day achieving universal acceptance. However, it is likely – at least for a while – that
28 some ACGME programs will continue to prefer to receive a USMLE score";¹⁰⁰ and
29

30 Whereas, Equal acceptance of COMLEX and USMLE would still enable allopathic medical
31 students to enter residency programs with osteopathic recognition since "Any graduate of a
32 college of medicine accredited by the Commission on Osteopathic College Accreditation
33 (COCA), medical school within the United States or Canada accredited by the Liaison
34 Committee on Medical Education (LCME), or medical school outside of the United States or
35 Canada that meets the established eligibility criteria will be eligible to enter an ACGME-
36 accredited program, including any program with Osteopathic Recognition";³ therefore be it
37

38 RESOLVED, That our American Medical Association promote equal acceptance of the USMLE
39 and COMLEX at all United States residency programs (New HOD Policy); and be it further
40

41 RESOLVED, That our AMA work with appropriate stakeholders including but not limited to the
42 National Board of Medical Examiners, Association of American Medical Colleges, National
43 Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education
44 and American Osteopathic Association to educate Residency Program Directors on how to
45 interpret and use COMLEX scores (Directive to Take Action); and be it further
46

47 RESOLVED, That our AMA work with Residency Program Directors to promote higher
48 COMLEX utilization with residency program matches in light of the new single accreditation
49 system. (Directive to Take Action)

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

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RELEVANT AMA POLICY

ACGME Residency Program Entry Requirements H-310.909

Our AMA supports entry into Accreditation Council on Graduate Medical Education (ACGME) accredited residency and fellowship programs from either ACGME-accredited programs or American Osteopathic Association-accredited programs. Res 920, I-12

Potential Impact of the USMLE Step 2 CS and COMLEX-PE on Undergraduate and Graduate Medical Education D-275.981

Our AMA will: (1) continue to closely monitor the USMLE Step 2 CS and the COMLEX-USA Level 2-PE, collecting data on initial and final pass rates, delays in students starting residency training due to scheduling of examinations, economic impact on students, and the potential impact of ethnicity on passing rates; and (2) encourage residency program directors to proactively evaluate their access to resources needed to assist resident physicians who have not passed these examinations to remediate. CME Rep. 4, A-04; Modified: CME Rep. 2, A-14

Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934

Our AMA adopts the following principles: (1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems, as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants. CME Rep. 8, A-99; Reaffirmed: CME Rep. 4, I-01; Reaffirmed: CME Rep. 2, A-11; Modified: CME Rep. 2, A-12

Independent Regulation of Physician Licensing Exams D-295.939

Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system; (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX).
Citation: CME Rep. 10, A-08; Modified: CME Rep. 01, A-18

Clinical Skills Assessment During Medical School D-295.988

1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.
2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.
4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.
5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.
6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.
7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary. CME Rep. 7, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: Alt. Res. 311, A-16; Appended: CME Rep. 09, A-17

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

Citation: Res. 307, A-09; Appended: Res. 955, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 956
(I-18)

Introduced by: Nebraska

Subject: Increasing Rural Rotations During Residency

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

1 Whereas, Residents of rural areas are generally older and sicker than their urban counterparts;
2 and

3
4 Whereas, Rural areas are facing a crisis due to physician shortages; and

5
6 Whereas, Residents and fellows are more likely to practice where they train; and

7
8 Whereas, Many residency programs offer elective rotations where residents can pursue areas
9 of interest not offered in their main residency curriculum; and

10
11 Whereas, The documentation requirements for faculty supervising residents can be substantial;
12 therefore be it

13
14 RESOLVED, That our American Medical Association work with state and specialty societies,
15 medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education
16 (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested
17 stakeholders to encourage and incentivize qualified rural physicians to serve as preceptors,
18 volunteer faculty, etc. for rural rotations in residency (Directive to Take Action); and be it further

19
20 RESOLVED, That our AMA work with the ACGME, the American Board of Medical Specialties,
21 the Federation of State Medical Boards, CMS and other interested stakeholders to lessen or
22 remove regulations or requirements on residency training and physician practice that preclude
23 formal educational experiences and rotations for residents in rural areas (Directive to Take
24 Action); and be it further

25
26 RESOLVED, That our AMA work with interested stakeholders to identify strategies to increase
27 residency training opportunities in rural areas with a report back to the House of Delegates
28 (Directive to Take Action); and be it further

29
30 RESOLVED, That our AMA work with state and specialty societies and other interested
31 stakeholders to identify appropriately qualified rural physicians who would be willing to serve as
32 preceptors for rural rotations in residency (Directive to Take Action); and be it further

33
34 RESOLVED, That our AMA work with the ACGME and other interested stakeholders to lessen
35 the documentation requirements for off-site rural rotations during residency so that affiliated
36 rural supervising faculty can focus on educating rotating residents (Directive to Take Action);
37 and be it further

1 RESOLVED, That our AMA work with interested stakeholders to study other ways to increase
2 training in rural areas (Directive to Take Action); and be it further
3

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

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

Received: 09/28/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 957
(I-18)

Introduced by: Florida

Subject: Board Certifying Bodies

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

Whereas, The United States Department of Justice, Antitrust Division, set forth its views on Maryland House Bill 857 in a letter dated September 10, 2018 addressed to Dan K. Morhaim, M.D., a member of the Maryland House of Delegates; and

Whereas, The Division's letter focused on two questions – first, whether ABMS may harm competition by imposing overly burdensome conditions on physicians who wish to maintain their ABMS certification; and second, what are the policy options available to the Maryland legislature if the legislature concludes that the ABMS Program for Maintenance of Certification (MOC) program harms healthcare competition in Maryland; and

Whereas, The Division's letter recognized that “more entry and more competition by bona fide certifying bodies may offer important benefits – including lowering the costs for physicians to be certified or improving the quality of certification services – for healthcare providers, consumers, and payers”; and

Whereas, The Division's letter encouraged the Maryland legislature to consider ways to facilitate competition by legitimate certifying bodies, consistent with patient health and safety, and, towards that end, encouraged drafters of Maryland House Bill 857 to consider ways to allow for entry by additional, legitimate certifying bodies; and

Whereas, Multiple states are pursuing legislation to address issues arising from a lack of competition among bona fide certifying bodies; therefore be it

RESOLVED, That our American Medical Association conduct a study of the certifying bodies that compete with the American Board of Medical Specialties and issue a report opining on the qualifications of each such certifying body and whether each such certifying body should be added to the list of approved certifying entities in states where they are not currently approved (Directive to Take Action); and be it further

RESOLVED, That our AMA develop model state legislation that would encourage competition among qualified certifying bodies and would modify board certification requirements such that maintenance of certification participation would not be a requirement for board recertification. (Directive to Take Action)

Fiscal Note: Estimated cost to implement the resolution is \$30,000.

Received: 09/27/18

RELEVANT AMA POLICY

Maintenance of Certification H-275.924

AMA Principles on Maintenance of Certification (MOC)

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (*AMA PRA Category 1 Credit*", American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
 22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
 23. Physicians with lifetime board certification should not be required to seek recertification.
 24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
 25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
 26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in MOC.
 27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.
- Citation: CME Rep. 16, A-09; Reaffirmed: CME Rep. 11, A-12; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 919, I-13; Appended: Sub. Res. 920, I-14; Reaffirmed: CME Rep. 2, A-15; Appended: Res. 314, A-15; Modified: CME Rep. 2, I-15; Reaffirmation A-16; Reaffirmed: Res. 309, A-16; Modified: Res. 307, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 319, A-17; Reaffirmed in lieu of: Res. 322, A-17; Modified: Res. 953, I-17

An Update on Maintenance of Licensure D-275.957

- Our American Medical Association will:
1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.
 2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues.
 3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce.
 4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL.
 5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may help shape and support MOL for physicians.
 6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.
 7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.
 8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time.
- Citation: (CME Rep. 3, A-15; Modified: CME Rep. 2, I-15)

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.)

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

10
11 While the ratio of members per delegate has been adjusted over the last 100 plus years to
12 accommodate growth in the physician population and membership, delegate apportionment has
13 always been based upon the number of current members. The current ratio of one delegate per 1000
14 AMA members dates from 1946. The 1948 constitution prescribed that the "number of delegates from
15 the constituent associations shall be proportional to the number of active members in the respective
16 associations," and that year saw the start of the annual apportionment process.

17
18 Two significant changes were effected in the early 1950s. At the December 1950 meeting, the
19 members to be counted were explicitly defined to be AMA members: "The apportionment of
20 delegates from each constituent association shall be one delegate for each thousand (1,000) or fraction
21 thereof, *dues paying active members of the American Medical Association* (emphasis added)."
22 Whereas before this time counts focused on members of the constituent associations, now the relevant
23 population was specified to be AMA members.* At the 1952 Annual Meeting, December 31 was set
24 as the cutoff date for counting members to maximize the time allowed for societies to add members,
25 with the effective date for apportionment January 1 (Proceedings of the House of Delegates, 1952).

26
27 Irrespective of how or when members join our AMA, under our current bylaws delegates are
28 apportioned to constituent societies and national medical specialty societies at the rate of one delegate
29 per 1000, or fraction thereof, AMA members as of December 31.[†] That is, one must be a member on
30 December 31 to be counted for apportionment purposes. The apportionment is effective January 1 of
31 the following year and is effective for one year. (See bylaws 2.1.1 and 2.2.1 and subsections.) Thus,
32 for example, if a society has 1000 AMA members on December 31, it will be apportioned one
33 delegate for the following year. A society with 1001 members will be apportioned two delegates.
34 (Although they are endorsed by and seated with constituent and national medical specialty societies
35 seated in the House of Delegates, separate bylaws provisions address the regional medical student and
36 sectional resident delegates who are apportioned differently.)

37
38 Because of differences in data availability and because delegate apportionment for constituent
39 societies determines the overall delegate apportionment for national medical specialty societies,
40 characterizations below are couched in terms of constituent societies. Figures for those societies are
41 also more easily captured in real time.

* To be clear, under the 1901 constitutional revision, AMA membership was granted to all members of local medical societies affiliated with state medical societies who applied for membership, supplied certification and paid the annual fee. In 1899, the annual dues were \$10 (*Caring for the Country*, 1997, pages 40-41).

[†] Member counts for constituent (ie, geographic) societies are determined annually. The overall number delegates apportioned to constituent societies determines the total number of delegates apportioned to national medical specialty societies, with the number of delegates apportioned to any particular specialty society *generally* tied to that society's most recent five-year review.

1 APPORTIONMENT UNDER RESOLUTION 604

2
3 As written, Resolution 604-A-18 calls for two enumerations of AMA membership, with the first
4 being the usual year-end calculation and the second being a count of members in approximately mid-
5 January. The larger of the two figures would be used for delegate apportionment. Unspecified is who
6 would be counted in the mid-January enumeration. While the count should clearly include those
7 whose now current year's dues have been paid, it should properly exclude individuals who have not
8 paid their appropriate dues by mid-January, as knowing who will (or will not) renew their
9 membership is not possible. A substantial number of members unfortunately do not renew annually,
10 and many members pay their current year dues after mid-January. Given these factors it seems likely
11 that a mid-January count of current year dues paying members would almost certainly be lower than
12 the year end count.

13
14 Calculations by AMA's Membership Group suggest that the magnitude of the difference of the two
15 counts would depend on the date of the second count. The largest number of AMA members is
16 recruited through AMA's own direct channel, and in any given year the vast majority of current year
17 members have typically joined by February. Consequently, one might advocate for a count in early
18 March or later, but even such a later count would exclude members who join later in the year,
19 particularly the large number of medical students and residents who typically join in summer or fall.
20 Pushing the count to a later date would also shorten the time for societies to adjust their delegation
21 size when necessary.

22
23 In light of the ambiguity regarding who would be counted, prior to June's House of Delegates
24 meeting Georgia, the sponsor of Resolution 604-A-18, proposed that the first resolve would be
25 implemented by counting for apportionment purposes current nonmembers who join the AMA for the
26 succeeding year during the current year. That discussion as well as comments during the reference
27 committee hearing suggested a revision of the first resolve to call for "the number of new AMA
28 members who have already paid their dues for a membership that officially begins on January 1 of the
29 following year will be included in the annual year-end count of AMA members, for the purposes of
30 AMA Delegation entitlements for state and national specialty societies for that following year." For
31 example, a nonmember in 2018 who during calendar year 2018 joins (and pays dues) for the 2019
32 membership year would be counted as a member in apportioning delegates for the 2019 calendar
33 year. Hereinafter these are referred to as "pending members," as their active membership is still
34 pending on December 31.

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

42
43 Data from year-end 2017, which were used for delegate allocation in 2018, indicate that five states
44 would have gained a delegate this year if pending members had been included. The states that would
45 gain in the future, however, depend on whether the addition of pending members pushes them across
46 the threshold for an additional delegate. For example, only two of the four states currently needing
47 fewer than 100 pending members to gain a delegate position would benefit, while among the 10 states
48 that had the largest number of pending members (range 261–691) at the end of 2017, only the first
49 and third largest would have picked up a delegate. The other three states that would have added a
50 delegate using this method at the end of 2017 did not have the largest number of pending members,
51 but the figure would push them over the additional delegate threshold. In other words, it would be the

1 combination of pending members and actual members that determines which states would benefit
2 from the change, adding an element of chance to the apportionment process.

3 4 DISCUSSION

5
6 Other than changes due the inclusion of more societies in the House of Delegates (and discounting
7 freezes), the rules for apportioning delegates to constituent societies have remained essentially
8 unchanged since 1952. For over a century, the apportionment rules have been based on current
9 membership, and for seventy years it has been recognized that apportionment should be conducted
10 annually to address membership fluctuations.

11
12 Another issue related to the counting of members warrants further discussion. Counting pending
13 members, individuals who “join” our AMA at the end of a current year but whose memberships are
14 not effective until the following year, means that one membership for AMA purposes effectively
15 counts for two years membership for delegate allocation purposes. In addition, this could result in
16 counting members for apportionment purposes that subsequently request a refund and are therefore
17 never actual dues paying members in either year. Gaming of such a system would be possible, with
18 for example panels of one-year members joining in alternate years or signing up for membership and
19 then requesting a refund, which is generally provided upon request in the first half of a calendar year.

20
21 Membership accounting can only allocate the membership to the year for which dues are paid, so
22 membership figures used for apportionment figures that include pending members would be
23 inconsistent with figures reported in our AMA’s annual report. Both the apportionment figures and
24 the official membership numbers are publicly available on the AMA website, which would require
25 the divergent apportionment figures to include an explanatory note. It might also be noted that
26 adjustments are not made during the year for losses such as deaths, resignations or CEJA actions that
27 remove an individual from the membership rolls.

28
29 While no effort to recruit members to our AMA should be discounted, among current members the
30 most often cited reason for belonging to our AMA is advocacy on behalf of the profession. This has
31 been true for many years, and although the value of enhanced representation in the House of
32 Delegates is often promoted to prospective members, little evidence supports the idea that physicians
33 join our AMA because of the House of Delegates per se. Rather, the advocacy that stems from House
34 actions is the more valued commodity. Indeed, the average physician—member or not—knows little
35 about the House of Delegates and AMA policymaking processes. The prospect of enhanced
36 representation may be a serviceable argument in the member recruitment quiver, but more successful
37 appeals address current AMA activities dealing with critical matters of public health, medical
38 education, practice sustainability and advocacy. Our AMA’s current Members Move Medicine™
39 campaign is based on this well-established foundation. The current apportionment system occurring at
40 the end of the year recognizes the recruitment that occurs throughout the year, including the
41 significant recruitment of medical students and residents that typically occurs well into the year.

42
43 Finally, some costs would be associated with the change. Our AMA would incur the expense of
44 rebuilding the counting procedures and maintaining the distinct records necessary for membership
45 accounting and apportionment processes. The associated complexity and expense would be greater if
46 the selected methodology demanded counting pending and current members rather than a simple
47 change in date of apportionment. Societies in the House of Delegates could incur the intangible cost
48 of some uncertainty in the number of delegates, which would depend on the counting scheme actually
49 adopted, along with the real expense of supporting additional delegates. None of these costs are easily
50 quantified.

51 RECOMMENDATION

1
2 The decision to count pending members for delegate apportionment purposes is clearly within the
3 purview of the House. It would require revisions of the bylaws before it can be implemented with
4 issues of how to handle those who join and those who no longer are AMA members during a calendar
5 year after a fixed point in time of deciding HOD apportionment has occurred.[‡] The apparent concern
6 about disenfranchising a new AMA member whose membership is effective after apportionment is
7 readily addressed through the online member forums. With access to online member forums before
8 HOD meetings, that AMA member can have active voice and influence in AMA policymaking.
9

10 The House of Delegates has for over a century counted only current members (ie, dues paid and
11 received by AMA) in determining delegate apportionment. The idea that pending members should be
12 added to the current membership seems unwarranted. It effectively double counts individuals, counts
13 members who may or may not rejoin, artificially increases the size of the House of Delegates by
14 including nonmembers in determining representation among Federation societies, and creates
15 opportunities for abuse. Insofar as these pending members will be counted for apportionment
16 purposes for the next cycle when they are actually members, arguments about fairness and
17 representation seem overstated. Finally, under current bylaws any constituent society that may lose a
18 delegate based upon the previous year final count is given a full year to recruit and retain members to
19 retain their delegate count. For these reasons, the Board of Trustees recommends that Resolution
20 604-A-18 not be adopted and the remainder of this report be filed.

Fiscal note: None

[‡] Some bylaws issues are not clear cut. Bylaw 2.1.1.1.1, for example, allows a constituent society to retain a delegate in the event of a loss of AMA members. Whether so called “pending members” should be allowed to offset losses in “actual members” certainly merits discussion.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-I-18

Subject: Training Physicians in the Art of Public Forum
(Resolution 606-A-18)

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

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

1 INTRODUCTION

2
3 At the 2018 Annual Meeting, the House of Delegates referred Resolution 606 as introduced by the
4 delegation from New Jersey to the Board of Trustees, to investigate a proposal that the AMA
5 should “establish a program for training physicians in the art and science of conducting public
6 forums in order to ensure that the public is well informed on the health care system of our country.”
7

8 Within the reference committee, there was considerable supportive testimony about the need to
9 improve physicians’ ability to speak publicly. Several who testified believed that the resources
10 needed to undertake training in public speaking are already available throughout the Federation and
11 could be utilized instead of creating new training materials. However, others believed that
12 developing the ability of physicians to positively present themselves in the public arena is too
13 important to leave to other organizations, and that training in public speaking could be offered as a
14 valuable AMA member benefit.
15

16 In evaluating the goal and the desired outcome, it is important to survey the existing landscape of
17 resources available to physicians to help inform AMA’s approach.
18

19 BACKGROUND

20
21 The leading organization that assists individuals with public speaking and leadership development
22 is Toastmasters International. Individuals can improve their speaking and leadership skills by
23 attending one of the 16,400 clubs worldwide. By regularly giving speeches and receiving feedback,
24 individuals can learn to tell their stories and leverage their voices.
25

26 AMPAC, the bipartisan political action committee of the American Medical Association, provides
27 high level training to physicians who are considering pursuit of elected office. For those who want
28 to campaign for public office and advocate for issues important to patients and physicians, this is a
29 premiere training program and valuable resource for physicians.
30

31 Other general communication resources available by the AMA include STEPS Forward modules
32 on topics like “Conducting Effective Team Meetings” and “Implementing a Daily Team Huddle.”
33

34 Within the Federation, several physician groups provide opportunities for training on effective
35 communications, including the American College of Physicians, American Academy of Family
36 Physicians, and the American Medical Women’s Association.

1 Perhaps the leader in providing this training to physicians is the American Association of Physician
2 Leadership (AAPL). Training topics offered by this organization include: "Present like a Pro,"
3 "Delivering Effective Feedback," "Fundamentals of Physician Leadership: Communication," and
4 "Improving Communication and Feedback in Healthcare Leadership." Courses are offered online
5 or in-person. Many of the self-study courses offer the option to watch the video lectures or attend
6 the sessions. A majority of the courses are accessible for up to three years after purchase. The
7 organization also offers live education courses that allow physicians to network with their peers.
8 There are also faculty-led courses that allow physicians to participate in discussions and case
9 studies throughout a six-week class session.

10 11 RECOMMENDATION

12
13 Physicians who want to learn more about public speaking can leverage existing resources both
14 within and outside the AMA. AMA can make public speaking tips available through online tools
15 and resources that would be publicized on our website. Physicians and physicians-in-training who
16 want to publicly communicate about the AMA's ongoing work are invited to learn more through
17 the AMA Ambassador program.

18
19 Meanwhile, STEPS Forward provides helpful tips to physicians wanting to improve
20 communication within their practice and AMPAC is available for physicians who want to advocate
21 and communicate about the needs of patients and physicians in the pursuit of public office. There
22 are also resources provided to physicians at various Federation organizations and through AAPL to
23 support those who are interested in training of this nature.

24
25 Because public speaking is a skill that is best learned through practice and coaching in a small
26 group or one-on-one setting, we also encourage individuals to pursue training through their state or
27 specialty medical society or through a local chapter of Toastmasters International.

28
29 The Board of Trustees recommends that the AMA's Enterprise Communications and Marketing
30 department work to develop online tools and resources that would be published on the AMA
31 website to help physicians learn more about public speaking in lieu of Resolution 606-A-18 and the
32 remainder of the report to be filed. (Directive to Take Action)

Fiscal Note: \$20,000 for professional fees for external support and capacity to develop these tools
and resources.

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-I-18

Subject: Women Physicians Section Five-Year Review

Presented by: Alfred Herzog, MD, Chair

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

1 AMA Bylaw 7.0.9 states, “A delineated section must reconfirm its qualifications for continued
2 delineated section status and associated representation in the House of Delegates by demonstrating
3 at least every 5 years that it continues to meet the criteria adopted by the House of Delegates.”
4 AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and
5 Development (CLRPD) is “to evaluate and make recommendations to the House of Delegates,
6 through the Board of Trustees, with respect to the formation and/or change in status of any section.
7 The Council will apply criteria adopted by the House of Delegates.”
8

9 The Council analyzed information from the letter of application submitted by the Women
10 Physicians Section (WPS) for renewal of delineated section status.
11

12 APPLICATION OF CRITERIA TO THE WOMEN PHYSICIANS SECTION

13
14 Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within
15 the broader, general issues that face medicine. A demonstrated need exists to deal with these
16 matters, as they are not currently being addressed through an existing AMA group.
17

18 The WPS is the only AMA group that is dedicated to advocacy on women physician policy issues,
19 providing leadership development and educational opportunities for women, and monitoring trends
20 and issues that affect women in medicine and women’s health. Currently, the WPS represents more
21 than 82,000 AMA women members. According to 2017 data from the Association of American
22 Medical Colleges, the number of women enrolling in U.S. medical schools has exceeded the
23 number of men. Since 2015, the number of female matriculants has grown by 9.6%, while the
24 number of male matriculants has declined by 2.3%.
25

26 The WPS addresses three major concerns: 1) women in medicine professional issues, which
27 include discrimination, e.g., gender bias and income disparity; 2) under-representation of women
28 physicians in leadership positions in organized medicine and academic medicine, which includes
29 disproportionate representation of women physicians in the AMA House of Delegates (HOD); and
30 3) health issues that disproportionately or uniquely affect women patients.
31

32 CLRPD assessment: The mission of the WPS is to provide a dedicated forum within the AMA to
33 increase discussion of and advocacy on women physician issues and strengthen the AMA’s ability
34 to represent this physician constituency. The WPS provides advice and counsel to the Association
35 on policy and program issues of interest to women physicians, and offers suggestions for activities
36 that best meet the needs of this physician segment. No other groups or sections within the AMA
37 specifically address the unique issues of concern of women physicians and patients.

1 Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the
2 AMA. Activities make good use of available resources and are not duplicative.

3
4 Over the past five years, the WPS has aligned its strategic goals with the AMA to find ways to
5 promote the efforts of the three strategic arcs. The Section's educational programs were in
6 support of topics that highlighted AMA priority issues such as physician burnout, continuing
7 education, and the opioid epidemic. Overall, the WPS supports the AMA's objectives by
8 reviewing new AMA products and services, providing insights on policy and advocacy
9 positions, and creating new ways to reach out to members and potential members.

10
11 The WPS collaborates with other groups to help improve the impact of the Section's key goals.
12 During the 2017 Annual Meeting of the HOD, the WPS collaborated with the Medical Student
13 Section to offer two programs: 1) a session that allowed medical students to connect with WPS
14 Governing Council (GC) members to discuss such topics as choosing a residency, communicating
15 with patients, developing leadership skills, critical decision making, careers in academic medicine,
16 and contract negotiation; and 2) "Occupational Health through a Gender-Conscious Lens." The
17 WPS has collaborated with other AMA sections on educational offerings: the WPS, Integrated
18 Physician Practice Section, and Organized Medical Staff Section program, "Transforming Roles in
19 Healthcare Leadership: How physicians can effectively communicate with non-physician leaders";
20 and the multi-sections' program, "Gun Violence: What do we know? What can physicians do?"

21
22 Additionally, the WPS leads the AMA's Women in Medicine Month each September. During this
23 time, the WPS implements two major programs:

- 24
25 1. Inspirational Physicians Recognition Program (formerly the Physician Mentor Recognition
26 Program). The WPS provides an opportunity for physicians to express appreciation to the
27 special men and women who have offered time, wisdom and support throughout their
28 professional journeys.
29 2. Joan F. Giambalvo Fund for the Advancement of Women (formerly the Giambalvo
30 Memorial Scholarship Fund). The AMA Foundation in association with the WPS
31 established the Fund with the goal of advancing the progress of women in the medical
32 profession, and strengthening the ability of the AMA to identify and address the needs of
33 women physicians and medical students.

34
35 In 2016, the WPS hosted its Women in Medicine Symposium at AMA headquarters, which
36 included presentations, panel discussions and breakout sessions covering physician resiliency and
37 burnout, overcoming obstacles in daily practice, and physician wellness techniques.

38
39 Over the last five years, the Section has worked collaboratively with various physician groups to
40 expand the influence of the WPS. Some of these efforts have included strong working relationships
41 with the leadership of other sections, representation on the AMA Alliance's Women in Medicine
42 Task Force, and the renaming and expansion of the liaisons program to the WPS Associates
43 Program.

44
45 CLRPD Assessment: The WPS serves its constituents by bringing professional issues unique to
46 women physicians to the forefront of organized medicine, and by providing targeted educational
47 programs and resources for the policymaking process.

48
49 Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and
50 activities.

The WPS GC is structured as an eight-member group elected by the WPS membership. Designated positions on the GC are delegate, alternate delegate, member-at-large (2), Medical Student Section representative, Resident and Fellow Section representative, Young Physicians Section representative, and American Medical Women's Association representative.

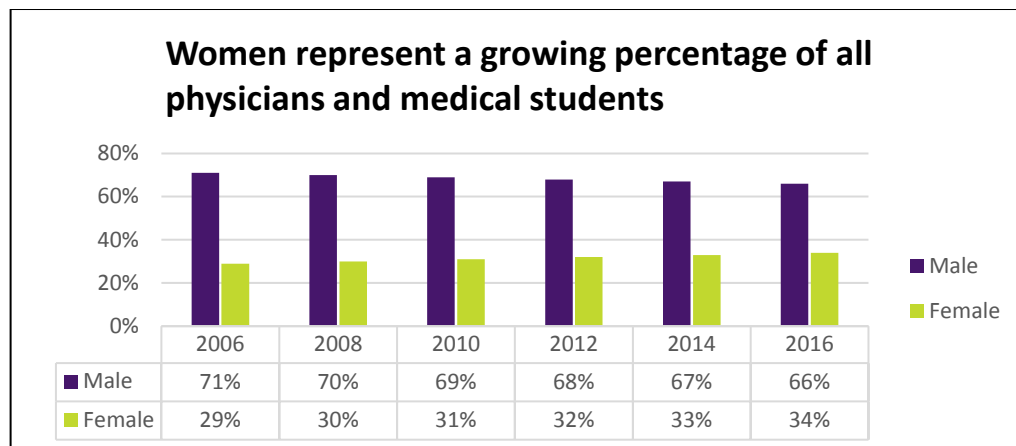
All members of the WPS are eligible to be elected to any office, except the member at-large positions that may not be assumed by medical students. If a candidate is serving on a HOD delegation, they must be willing to resign from their respective HOD delegation position if elected as the WPS delegate or alternate delegate. Lastly, the GC elects its chair and vice chair for the upcoming year in a closed session at each Annual HOD Meeting.

The WPS is developing a five-year strategic plan to assess the progress that the Section has made in advancing women in the medical profession, strengthening the ability of the AMA to address the needs of women physicians and medical students, and what WPS hopes to achieve by 2023.

CLRPD Assessment: The WPS convenes a GC from its members and holds strategic planning meetings to plot its annual and long-term goals, and ensure alignment with the goals of the AMA. All Section members have opportunities throughout the year to contribute to the deliberations of the WPS either in person or by virtual means such as HOD Online Forums, listservs, Twitter and special interest Facebook groups.

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

According to CLRPD Report 1-A-07, Demographic Characteristics of the House of Delegates and AMA Leadership, in 2006, 309,617 (29%) of U.S. physicians and medical students were female, and comprised 25.6% of AMA members. When the Women Physicians Congress became a section in 2013, CLRPD Report 2-A-13 indicated a growing number of female physicians and medical students (380,050), which comprised 31.3% of AMA members. According to CLRPD Report 2-A-17, there are 82,491 female AMA members (34.3% of AMA membership) and women make up 34.0% of all U.S. physicians and medical students. According to the same CLRPD report, there are 435,099 women physicians and medical students in the United States. Thus, WPS membership comprises 19% of this physician segment.



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

Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this Section and both the segment and the AMA will benefit from an increased voice within the policymaking body.

AMA Bylaw 7.10.1 states, "All female physicians and medical students who are active members of the AMA shall be eligible to be members of the Women Physicians Section. Other active members of the AMA who express an interest in women's issues shall be eligible to join the Section."

Based on AMA Physician Engagement's analysis, the WPS unit experienced a 5% increase of interactions with women physicians and medical students from 2015 to 2016. Overall, the following changes drove improvement:

1. The Women Physicians Congress transitioned from an advisory group to the WPS in 2013.
2. WPS members have the ability to create policy and have a voice in the HOD.
3. The AMA increased communication directed at women physicians.
4. All WPS members with a valid email address in the AMA's database receive a monthly newsletter from the Section.
5. WPS members are encouraged to contribute to the policymaking processes of the Section and provide input into programs and products.

Additionally, the WPS developed a social media plan to further member engagement efforts. During the 2016 Women in Medicine month:

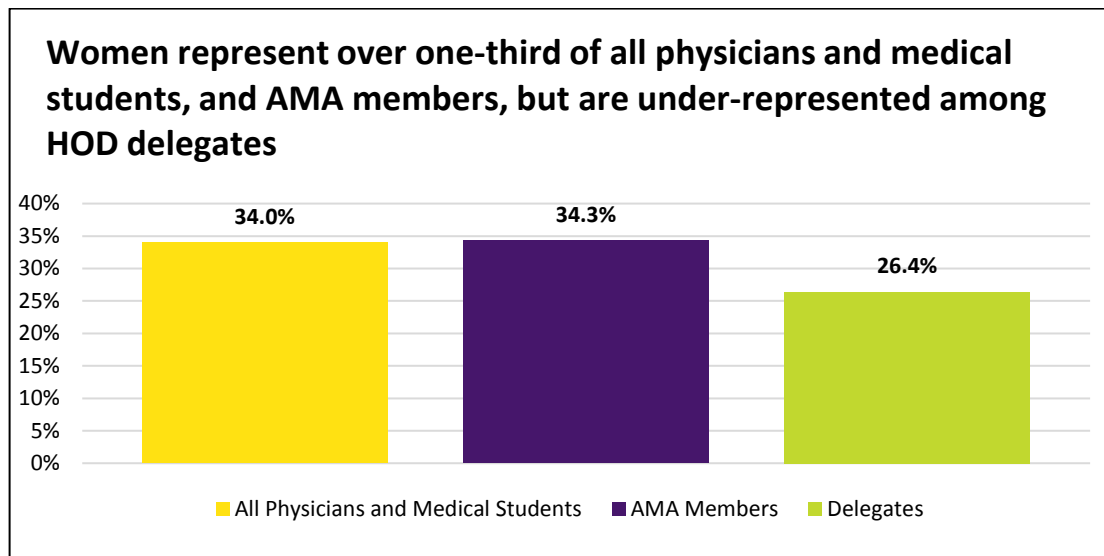
- Facebook posts totaled 1,186,889 impressions and 14,950 acts of engagement, reflecting 31% and 25% increases over 2015 numbers, respectively.
- Twitter posts totaled 287,665 impressions, reflecting a 21% increase over 2015 numbers.
- The WPS webpage experienced a 34% increase in traffic compared to the previous year. Similarly, there was a 16% increase in traffic to the Women In Medicine webpage in 2016.

In the 2017 GC elections, 1,732 WPS members voted. The number of voters has increased every year. During the first WPS election in 2015, 936 WPS members took part in the election. Nominations for leadership positions were also up by 35% over last year. This increase was driven by promotional efforts in *AMA Wire*, targeted outreach to the Federation, and the identification of new communication channels such as the Women in Otolaryngology Listserv and special interest Facebook groups.

CLRPD Assessment: WPS meetings, elections, and educational sessions are well attended, and demonstrate increasing engagement, while strategies are in place to further grow participation. The population of potential WPS members continues to expand. The AMA has benefited from an increased voice of WPS members within the policymaking body of the Association.

Criterion 6: Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the HOD.

From 2008 to 2016, the percentage of female delegates increased from 19.3% to 26.4%. While this increase is important, in 2016, women represented 34% of all U.S. physicians and medical students, and 34.3% of all AMA members. However, just 26.4% of delegates and 28.4% of alternate delegates were female, which indicates this segment is under-represented in the HOD.



The WPS policymaking process begins with an open call to the Section's membership for resolutions. Concurrently, the WPS policy committee works to identify topics for potential resolutions. Resolutions are vetted by WPS staff and the AMA legal team. Accepted resolutions are presented to the Section's membership for comment via an online forum. The WPS GC reviews the comments and approved resolutions are placed online for ratification. Ultimately, the ratified resolutions are submitted to the HOD.

The WPS convenes a HOD Handbook Review Committee prior to each HOD meeting. The process involves several members of the WPS who evaluate all resolutions and reports under consideration. The Committee usually reaches consensus on 95% of the items and the GC determines the Section's position on the remaining 5%. During the WPS business meeting, the delegate and alternate provide an open forum to discuss the Section's active positions on HOD items of business. All attendees are welcome to participate and provide insights on reports and resolutions. The process allows for discussion and development of a position, to support, monitor or oppose, which guides the delegate and alternate delegate as they testify on behalf of the Section. The WPS typically submits 3-4 resolutions to the HOD per meeting. Over the past four years, the Section has introduced 20 resolutions to the HOD.

Over the past four years, the Section has submitted resolutions related to WPS topics of concern: Tubal Ligation and Vasectomy Consents, Impact of Pharmaceutical Advertising on Women's Health, A New Definition of "Women's Health," Off-Label Use of Hormone Therapy, Heart Disease and Women, Medical Necessity of Breast Reconstruction and Reduction Surgeries, Women and Alzheimer's Disease, Women and Pre-exposure prophylaxis (PrEP), Women and Mental Health, Research into Preterm Birth and Related Cardiovascular (CV) and Cerebrovascular

1 Risks (CVD) in Women, and Care of Women and Children in Family Immigration Detention.
2 Eighty-two percent of WPS submitted resolutions resulted in development of new AMA policy or
3 amendment of existing policy. The WPS provides its members with an opportunity to become
4 involved in the Section's HOD activities, such as delivering testimony on behalf of the Section
5 during reference committee hearings.
6

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

17 CLRPD Assessment: The WPS provides numerous opportunities for members of the constituency
18 to introduce issues of concern and participate in the HOD policymaking process. The WPS has
19 continually pursued ways to improve member communications and the resolution process; thereby,
20 encouraging member involvement. The WPS provides a formal structure for women physicians to
21 participate directly in the deliberations of the HOD and impact policy.
22

23 RECOMMENDATION

24

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

Fiscal Note: Less than \$500

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

REPORT OF THE BOARD OF TRUSTEES

B of T Report 9-I-18

Subject: Hospital Closures and Physician Credentialing
(Resolution 716-A-18)

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

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates (HOD) referred Resolution 716-A-18, “Hospital Closures and Physician Credentialing.” Resolution 716 was sponsored by the Organized Medical Staff Section and asked the AMA to:

work with appropriate stakeholders—such as the AMA Organized Medical Staff Section and National Association Medical Staff Services (NAMSS)—to produce an AMA credentialing repository that would allow hospitals and other organizations that credential physicians to access verified credentialing information for physicians who were on staff at a hospital (or one of its departments) at the time of closure, and report back at the 2018 Interim Meeting.

Testimony largely supported the intent of Resolution 716. However, some members noted that not only would the cost of implementing Resolution 716 be significant, but there are also many unanswered questions about the demand for such a service and how it would work. Other members were concerned as to whether the AMA is the organization best positioned to take up this issue.

DISCUSSION

Resolution 716 suggests that a lack of institutional policies for preserving medical staff credentialing files when a hospital closes can lead to undue delays in future credentialing efforts due to inaccessibility of historical credentialing information. To minimize the potentially devastating impact this shortcoming may have on physicians and other displaced medical staff members, Resolution 716 asks that the AMA create a centralized repository to facilitate the verification of credentialing information as it relates to a physician’s hospital affiliation history.

Existing AMA policy supports the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory surgery facilities, nursing homes and other health care facilities. Policy H-230.956, “Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records” states that, where in accordance with state law and regulations, “[t]he governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility...” and “...make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.” Policy H-230.956 also states that the closing facility “...shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information.”

Notwithstanding this comprehensive policy, a thorough review of existing law reveals few requirements for the retention of physician credentialing records when a hospital closes. While some states require hospitals to implement policies for the preservation of medical staff credentialing files (e.g., Illinois and New York), most states have no specific law or regulations providing for the timely transfer of medical staff credentialing files and proper notification to physicians of the location of those files. As a starting point, the AMA should encourage emulation of appropriate existing laws and regulations by developing model state legislation that supports timely physician access to credentialing files following the closure of a hospital.

Even if closing hospitals were required by law to preserve credentialing files, it remains to be seen where and how this information would be most appropriately stored. Resolution 716 suggests the development of a comprehensive and centralized repository of credentialing files from closed hospitals. States, payors, and other stakeholders are already in the process of developing credentialing repositories for verification of physicians' current and past hospital affiliations. For example, Oregon passed legislation to establish a centralized credentialing database from which medical staff professionals, hospitals, health plans, and other organizations can get up-to-date information on every licensed physician in the state. Additionally, the National Association Medical Staff Services (NAMSS) has launched an online repository to provide medical staff offices a place to quickly find and upload physician affiliation history. Either of these efforts could be expanded to address the problems raised by closed facilities. Recognizing the value that the AMA could provide alongside expert leaders in the credentialing industry, the AMA should continue to monitor these efforts and explore the feasibility of developing a universal clearinghouse that centralizes the verification of physician practice and affiliation history.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 716-A-18 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-230.956, which states that the governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility should be responsible for making arrangements for the disposition of physician credentialing records upon the closing of a facility and should make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, and medical staff status. (Reaffirm HOD Policy)
2. That our AMA develop model state legislation and regulations that would require hospitals to: (a) implement a procedure for preserving medical staff credentialing files in the event of the closure of the hospital; and (b) provide written notification to its state health agency and medical staff before permanently closing its facility indicating whether arrangements have been made for the timely transfer of credentialing files and the exact location of those files. (Directive to Take Action)
3. That our AMA: (a) continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations; and (b) explore the feasibility of developing a universal clearinghouse that centralizes the verification of credentialing information as it relates to physician practice and affiliation history, and report back to the House of Delegates at the 2019 Interim Meeting. (Directive to Take Action)

Fiscal Note: Modest – Between \$1,000 and \$5,000

Relevant AMA Policy

H-230.956, "Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records"

1. AMA policy regarding the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory surgery facilities, nursing homes and other health care facilities, where in accordance with state law and regulations is as follows:
 - A. Governing Body to Make Arrangements: The governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility.
 - B. Transfer to New or Succeeding Custodian: Such a facility shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information. In the alternative, the facility shall seek to make arrangements with a reputable commercial storage firm. The new or succeeding custodian shall be obligated to treat these records as confidential.
 - C. Documentation of Physician Credentials: The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.
 - D. Maintenance and Retention: Physician credentialing information and CME information transferred from a closed facility to another hospital, other entity, or commercial storage firm shall be maintained in a secure manner intended to protect the confidentiality of the records.
 - E. Access and Fees: The new custodian of the records shall provide access at a reasonable cost and in a reasonable manner that maintains the confidential status of the records.
2. Our AMA advocates for the implementation of this policy with the American Hospital Association.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-18

Subject: Prescription Drug Importation for Personal Use
(Resolution 226-I-17)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

At the 2017 Interim Meeting, the House of Delegates referred Resolution 226-I-17, “Prescription Drug Importation for Personal Use,” which was sponsored by the Minnesota delegation. Resolution 226-I-17 asked that our American Medical Association (AMA) support legislation that would allow for the personal purchase and importation of prescription drugs obtained directly from a licensed Canadian pharmacy, provided such drugs are for personal use and of a limited quantity. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2018 Interim Meeting.

This report addresses the in-person purchase and importation of prescription drugs obtained directly from a licensed, “brick-and-mortar” Canadian pharmacy, not the importation of drugs via online or mail-order pharmacies. The Council notes that Policy D-100.983 guides AMA advocacy on these aspects of the prescription drug importation issue, and states that our AMA will:

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

This report provides background on prescription drug pricing and spending in the United States and Canada; summarizes US federal law and regulatory authority addressing prescription drug

importation; highlights activities to ensure US pharmaceutical chain integrity; reviews how prescription drugs and pharmacies are regulated in Canada; outlines relevant legislative and administrative activity; and presents policy recommendations.

BACKGROUND

In 2016, the US had the highest pharmaceutical spending per capita in the world at \$1,443, versus \$613 in Canada. Retail spending on prescription drugs per capita was also highest in the US at \$1,026, with Canada's retail per capita spending amounting to roughly half that of the US. Public spending on prescription drugs accounted for 36 percent of total pharmaceutical spending in Canada, and 34 percent in the US. Private insurance accounted for 36 percent of total pharmaceutical spending in the US and 30 percent in Canada, with private out-of-pocket spending accounting for 34 percent in Canada, and 30 percent in the US.¹

Differential pricing for pharmaceuticals between the US and Canada reflects differences in how pharmaceutical prices are determined in each country. Contributing factors to pharmaceutical pricing include the level of government negotiation authority, price controls mandated by law, and market exclusivity and manipulations. In Canada, the Patented Medicine Prices Review Board, a federal, independent, quasi-judicial body, regulates the prices of patented medications to ensure that they are not excessive. Price increases of existing patented drugs cannot exceed the Consumer Price Index. Of note, the Board only regulates the price at which patented drugs are sold to wholesalers, hospitals, pharmacies and other entities by their respective patent holders, and does not have jurisdiction over wholesale or pharmacy prices. In addition, the Board only has the authority to regulate the prices of patented drugs, not generic drugs. Provinces have the authority over the pricing of generic drugs, as well as the pricing of prescription drugs under public drug plans.^{2,3} In addition, the pan-Canadian Pharmaceutical Alliance, with the participation of provinces, territories and federal drug plans, conducts joint negotiations for the pricing of publicly covered drugs.⁴

When faced with high out-of-pocket costs for prescription drugs, some patients in the US pursue the importation of their medications from other countries, including Canada. In fact, eight percent of respondents in a recent Kaiser Health Tracking Poll indicated that they or someone in their household had imported prescription drugs from Canada or other countries outside of the US.⁵

FEDERAL LAW ADDRESSING PRESCRIPTION DRUG IMPORTATION

Under current US law, based on provisions of the Medicare Modernization Act of 2003 as well as the Medicine Equity and Drug Safety Act of 2000, HHS has the authority to permit importation of prescription drugs from Canada if the HHS Secretary certifies to Congress that they would pose no additional risk to the public's health and safety, and would result in a significant reduction in the cost of the drugs to Americans. However, no HHS Secretary has been willing to provide the enabling certification for prescription drug importation, thus preventing its implementation.⁶ Because prescription drugs from other countries often have not been approved by the FDA for use and sale in the US, it generally remains illegal for individuals to import prescription drugs into the US for personal use. Without FDA approval and enforcement authority, the safety and effectiveness of imported drugs cannot be assured.

Current law, however, also gives the FDA discretion in enforcement of the importation of prescription drugs by individuals, which allows the FDA's "personal-use" or "compassionate-use" policy. Under the policy, the FDA allows the personal importation of prescription drugs under very limited circumstances, described by the agency as:

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

9

10 The FDA also has utilized its enforcement discretion to allow importation in the case of a shortage

11 of a prescription drug. In the case of such shortages, when manufacturers of an FDA-approved

12 prescription drug cannot resolve a shortage immediately, the FDA sometimes has had to turn to

13 foreign versions of the drug with the same active ingredient manufactured by firms the FDA deems

14 as reputable and reliable. As a result, the limited importation of the foreign version of the drug has

15 been allowed until the shortage is resolved.⁸ Of note, such enforcement discretion has been used

16 sparingly, including for propofol in 2010 and 2012, ethiodol in 2011 and 2015, methotrexate

17 injection and liposomal doxorubicin in 2012 and tretinoin capsules in 2016.⁹

18

19 US PHARMACEUTICAL SUPPLY CHAIN INTEGRITY

20

21 In the US, the FDA has the authority to ensure the integrity of the US pharmaceutical supply chain,

22 from raw materials to manufacturing facilities to use by patients. The FDA is undergoing several

23 initiatives to protect the global prescription drug supply chain, responding to the fact that

24 approximately 40 percent of finished prescription drugs are imported in the US, and 80 percent of

25 active pharmaceutical ingredients come from overseas sources. Such initiatives are targeted at

26 preventing substandard, adulterated and counterfeit drugs from entering the US, and appropriately

27 communicating risks to patients and providers. The FDA completed 4,936 Good Manufacturing

28 Practice inspections of registered drug and device establishments in 2017, and issues annual reports

29 outlining such inspections as well as the percentage of the FDA budget used to fund such

30 inspections. The FDA also has administrative detention authority to prevent the distribution or

31 subsequent use of drugs suspected to be adulterated or misbranded at the time of inspection until

32 the agency determines what action it should take concerning the drugs, including the initiation of

33 legal action.^{10,11} In addition, the FDA is working towards fully implementing the Drug Supply

34 Chain Security Act by 2023. The Act, which was Title II of the Drug Quality and Security Act, was

35 enacted into law in 2013 and outlines steps to build an electronic, interoperable system to identify

36 and trace certain prescription drugs as they are distributed in the US.¹²

37

38 CANADIAN REGULATION OF PRESCRIPTION DRUGS AND PHARMACIES

39

40 Health Canada reviews prescription drugs to assess their safety, effectiveness and quality before

41 they are authorized for sale in Canada, and performs continuous evaluations after such drugs are on

42 the market, including monitoring adverse reactions. Once approved for sale, prescription drugs in

43 Canada are issued an eight-digit Drug Identification number, which indicates that Health Canada

44 considers the drug safe and effective, and provides a mechanism to track adverse reactions. Also,

45 Health Canada licenses and conducts inspections of pharmaceutical manufacturers, importers and

46 distributors. In order to prevent unauthorized drug products from entering Canada, including

47 counterfeit and adulterated drugs, Health Canada works in cooperation and coordination with the

48 Canada Border Services Agency.^{13,14} The FDA has voiced its confidence in Health Canada in

49 providing effective oversight of drugs approved for use by Canadian patients.¹⁵

1 There are 10,947 licensed pharmacies in Canada, including 10,463 community pharmacies.¹⁶
2 Provincial and territorial pharmacy regulatory authorities regulate the practice of pharmacy and the
3 operation of pharmacies in their respective jurisdictions in Canada. This includes the licensing of
4 pharmacies in Canada, including traditional “brick-and-mortar” pharmacies and storefront
5 pharmacies that conduct business online.¹⁷
6

7 RELEVANT ADMINISTRATIVE AND LEGISLATIVE ACTIVITY

8

9 In response to the request of HHS Secretary Alex Azar in July 2018, a work group will assess how
10 to safely import prescription drugs from other countries under certain narrow circumstances not
11 involving a shortage, namely in the event of a significant price increase for a prescription drug that
12 is only produced by one manufacturer and not protected by patents or exclusivities. The FDA
13 Commissioner has stressed that if drugs that fall under this categorization can be imported in a
14 manner that ensures safety and effectiveness, such importation would be temporary until there is
15 sufficient competition.^{18,19}
16

17 In addition, legislation has been introduced to permit prescription drug importation. Legislative
18 approaches to prescription drug importation vary in many respects. For example, while some bills
19 focus on the importation of prescription drugs from Canada, therefore requiring the Secretary of
20 HHS to promulgate the necessary regulations on this issue, other bills could potentially allow
21 prescription drug importation from additional countries that meet standards for ensuring the safety
22 and effectiveness of drugs that are at least as protective as such standards in the US. Bills also vary
23 in defining the foreign pharmacies and entities from which individuals can import prescription
24 drugs.
25

26 Senator John McCain (R-AZ) and Congresswoman Chellie Pingree (D-ME) have introduced
27 S 64/HR 1480, the Safe and Affordable Drugs from Canada Act of 2017. S 64/HR 1480, if enacted
28 into law, would compel the HHS Secretary to promulgate regulations within 180 days permitting
29 individuals to import a prescription drug purchased from an approved Canadian pharmacy that: is
30 dispensed by a pharmacist licensed in Canada; is purchased for personal use in quantities not
31 greater than a 90-day supply; is filled using a valid prescription issued by a physician licensed to
32 practice in the US; and has the same active ingredients, route of administration, dosage form, and
33 strength as a prescription drug approved under the Federal Food, Drug, and Cosmetic Act. The
34 legislation does not authorize importation of certain medications, including controlled substances
35 and biological products. The bill establishes a certification process for approving Canadian
36 pharmacies and HHS would have to publish a list of approved Canadian pharmacies.^{20,21} Senator
37 McCain also introduced S 92, legislation with the same title and most of the same text as S 64, but
38 differing in that it would give HHS 185 days to promulgate regulations permitting individuals to
39 import a prescription drug purchased from an approved Canadian pharmacy instead of 180 days.²²
40

41 Congressman Keith Ellison (D-MN) has introduced HR 934, the Personal Drug Importation
42 Fairness Act of 2017. If enacted into law, the legislation would allow a drug to be imported by a
43 person other than the drug’s manufacturer if the drug has the same active ingredients, route of
44 administration, and strength as an approved drug. The bill also states that drugs could be imported
45 or reimported from the following countries if the FDA determines that they have standards for
46 ensuring drug safety and effectiveness that are at least as protective as US standards: Australia,
47 Canada, Israel, Japan, New Zealand, Switzerland, South Africa, a member-state of the European
48 Union, or a country in the European Economic Area. Prescription drugs to be imported would be
49 required to be dispensed by a licensed pharmacist; be shipped directly to, or imported by, the
50 ultimate consumer; and shipped or imported in quantities that do not exceed a 90-day supply. The
51 bill would prohibit the importation of controlled substances.²³

1 Senator Bernie Sanders (I-VT) and Congressman Elijah Cummings (D-MD) have introduced
2 S 469/HR 1245, the Affordable and Safe Prescription Drug Importation Act. If enacted into law,
3 the legislation would require HHS to issue regulations within 180 days allowing wholesalers,
4 licensed US pharmacies, and individuals to import qualifying prescription drugs manufactured at
5 FDA-inspected facilities from licensed Canadian sellers. After two years, the Secretary would have
6 the authority to permit importation from countries in the Organisation for Economic Co-operation
7 and Development that meet specified statutory or regulatory standards that are comparable to US
8 standards. The bill would prohibit the importation of controlled substances, anesthetic drugs
9 inhaled during surgery, and compounded drugs. The bill stipulates that an individual may import a
10 qualifying prescription drug for personal use in quantities not greater than a 90-day supply from an
11 online pharmacy or by a certified foreign seller that is a licensed foreign pharmacy. The bill also
12 would require that individuals importing qualifying prescription drugs must provide to the licensed
13 foreign pharmacy a valid prescription issued by a health care practitioner licensed to practice in the
14 US.^{24,25}

15
16 There also has been state activity in the arena of prescription drug importation. Nine states have
17 introduced drug importation legislation this year, with Vermont enacting a law that would allow
18 drug importation from Canada through authorized wholesalers.²⁶ The state is required to submit a
19 drug importation proposal for federal approval.²⁷ Without federal approval, Vermont's law will
20 face the same fate as Maine's, which was enacted in 2013 to allow its citizens to import
21 prescription drugs from Canada, New Zealand, Australia, and the United Kingdom. However, in
22 2015, a federal district court ruled that Maine's law was unconstitutional, as federal law preempts
23 state law on this issue.²⁸

24 25 DISCUSSION

26
27 Supporting the ability of US patients to purchase and import prescription drugs in-person from a
28 licensed Canadian pharmacy has the potential to improve patient cost-sharing levels if significant
29 cost savings could be achieved, which would positively address one barrier to medication
30 adherence. The Council notes that under such a policy, some patient medications, including
31 controlled substances and biologicals, may not be allowed to be imported. Nevertheless, the
32 Council believes that a risk to patients who pursue the importation of prescription drugs from
33 Canada remains, especially those who import such drugs via the Internet which increases the risk
34 of receiving substandard, adulterated and counterfeit drugs.

35
36 Policy D-100.983 provides a strong, balanced approach to guide the support of our AMA for the
37 legalized importation of prescription drug products by wholesalers and pharmacies, as well as the
38 personal importation of prescription drugs via the Internet. Critically, the policy predicates AMA
39 support for prescription drug importation on ensuring that safety concerns with imported
40 prescription drugs are addressed, to ensure that they are of the same quality and chemical makeup
41 as those currently distributed in the US. While in-person importation from licensed pharmacies in
42 Canada may face fewer safety concerns than importing prescription drugs via the Internet which
43 would then be shipped to patients, ensuring the safety of such imported drugs must remain a
44 priority. Therefore, the Council recommends that our AMA support the in-person purchase and
45 importation of prescription drugs obtained directly from a licensed Canadian pharmacy when
46 product integrity can be assured, provided such drugs are for personal use and of a limited quantity.
47 The Council also believes that the FDA needs new and additional resources to administer and
48 enforce a program that allows the in-person purchase and importation of prescription drugs from
49 Canada, if the safety of in-person importation can be assured.

Also addressing the critical issue of safety of imported prescription drugs, the Council recommends the reaffirmation of Policy D-100.985, which states that our AMA will continue to actively oppose illegal drug diversion, illegal Internet sales of drugs, illegal importation of drugs, and drug counterfeiting. In addition, the policy calls for our AMA to work with the Congress, the FDA, the Drug Enforcement Administration, and other federal agencies, the pharmaceutical industry, and other stakeholders to ensure that these illegal activities are minimized.

Allowing for the in-person importation of prescription drugs from licensed Canadian pharmacies is not a comprehensive, long-term solution to addressing the problem of unaffordability of prescription drugs in the US. The Council believes that sustainable solutions to addressing high and unaffordable prescription drug prices can be found by addressing the flaws and inefficiencies in the US pharmaceutical marketplace. However, patients that face high and unaffordable costs for their prescription drugs need relief in the meantime. Your Council believes that supporting the in-person purchase and importation of prescription drugs from Canada, if the safety of importation can be assured, represents a measured and conservative option to lower patient costs for prescription drugs.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 226-I-17, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support the in-person purchase and importation of prescription drugs obtained directly from a licensed Canadian pharmacy when product integrity can be assured, provided such drugs are for personal use and of a limited quantity. (New HOD Policy)
2. That our AMA advocate for an increase in funding for the US Food and Drug Administration to administer and enforce a program that allows the in-person purchase and importation of prescription drugs from Canada, if the integrity of prescription drug products imported for personal use can be assured. (New HOD Policy)
3. That our AMA reaffirm Policy D-100.983, which outlines criteria for supporting the legalized importation of prescription drug products by wholesalers and pharmacies, and opposes the personal importation of prescription drugs via the Internet until patient safety can be assured. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy D-100.985, which opposes the illegal importation of prescription drugs and drug counterfeiting, and supports working with Congress, federal agencies and other stakeholders to ensure that these illegal activities are minimized. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-18

Subject: Air Ambulance Regulations and Payments

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

At the American Medical Association’s (AMA) 2017 Interim Meeting, the House of Delegates adopted policy D-130.964, “Air Ambulance Regulations and Reimbursements,” which directs the AMA and appropriate stakeholders to study the role, clinical efficacy, and cost-effectiveness of air ambulance services, including barriers to adequate competition, reimbursement, and quality improvement.

This report provides background on air ambulances including an outline of the various air ambulance business models in the market, discusses the costs and insurance coverage of air ambulance services, summarizes relevant AMA policy, provides an overview of legislative activity on air ambulances, and suggests policy recommendations.

BACKGROUND

Helicopters provide emergency scene responses and interfacility transfers while fixed-wing aircraft provide longer distance airport-to-airport transports. For the purposes of this report, the Council focuses on helicopter air ambulances, which account for about 74 percent of all air ambulances and most of the research on air ambulances.¹ Furthermore, Policy D-130.964 directs the report’s scope to focus on the role, clinical efficacy, and cost for air ambulance services.

Air ambulances are used to expeditiously transport critically ill patients during life-threatening emergencies. Air ambulances are equipped with medical equipment and staffed by medical professionals similar to traditional ground ambulances. Air ambulances are widely considered to have a beneficial impact on improving the chances of survival and recovery for both trauma victims and other patients in critical condition. In some rural areas that lack advanced-care facilities like trauma centers, air ambulances fill a critical gap and provide patients timely access to the treatment they need.²

Air ambulances allow for optimization of patient care and outcomes. In emergency medicine, the “golden hour” refers to a time period lasting for about one hour following traumatic injury or medical emergency during which there is the highest probability that rapid medical treatment will prevent further deterioration or death. Air ambulances increase the likelihood of patients receiving needed care within the “golden hour” because of their ability to land at accident sites and quickly fly to nearby hospitals therefore reducing transport times. Unlike other aviation and medical services, air ambulance transfers take place in response to time-sensitive medical emergencies and generally are not scheduled ahead of time.³ Patients often have little to no ability to make cost-saving decisions before the transport, such as ensuring that the air ambulance provider participates in the patient’s insurance plan.

1 It is estimated that more than 550,000 patients in the US use air ambulance services every year.
2 Further, air ambulance services have increased significantly in recent years. In 2002, there were
3 about 400 air ambulances in use across the US, and that number more than doubled to over 800 air
4 ambulances by 2008.⁴ This increase in the number of air ambulances has sparked criticism from
5 consumer groups of oversupply and contributing to the overuse of air ambulance services that may
6 not be medically necessary. It is estimated that nearly a third of patients transported via air
7 ambulance helicopter were minimally injured.⁵ In addition to possible unnecessary use of air
8 ambulances, other reasons for the growth in the industry include an aging population, a decrease in
9 the number of emergency departments in hospitals, and changes in health care delivery in rural
10 settings.

11
12 Air ambulances have emerged as one solution to the problem of rural health care facility closures.
13 A quarter of Americans, or 85 million people, are estimated to be unable to access health care in
14 less than an hour of travel time without an air ambulance, and such ambulances may be the only
15 viable means of transporting patients to the care center they need.⁶ However, over the past decade,
16 many states have reported issues with air ambulance providers who are not affiliated with any
17 hospital or insurance carrier.

18 19 AIR AMBULANCE BUSINESS MODEL

20
21 Air ambulance providers generally function in one of three business models based on the entity that
22 owns the air ambulance and the individuals providing medical services aboard the aircraft. The first
23 model is a hospital-based model wherein the hospital provides medical services and staff and
24 typically contracts with third parties for the pilots, aircraft, and maintenance. The second model is
25 the independent model wherein operations are not controlled by a specific medical facility.
26 Independent models may consist of for-profit or non-profit providers who directly employ the
27 medical and flight crews to provide services. The third model is the government model where a
28 state, municipal government, or military unit owns and operates the air ambulances.⁷

29
30 Until 2002, air ambulances were primarily owned and operated by hospitals. However, in 2002,
31 Medicare created a national fee schedule for air ambulances based on a thorough investigation into
32 the “reasonable cost” for emergency medical services (EMS). The national fee schedule had the
33 effect of increasing the Medicare reimbursement rate for helicopter air ambulance transport and in
34 particular raising the rate of payment for rural air transports.⁸

35
36 Due in part to the establishment of the fee schedule, for-profit companies established and expanded
37 their air ambulance businesses. Currently, it is estimated that more than half of the air ambulance
38 industry is controlled by four for-profit air ambulance operators. The doubling of the number of air
39 ambulances since 2002 potentially may be attributed to the closure of clinics and hospitals in rural
40 areas.

41 42 COST AND COVERAGE OF SERVICES

43
44 Patients typically have little to no choice over the service or provider of an air ambulance due to the
45 urgent nature of the transports. Furthermore, air ambulance providers generally do not turn away
46 patients based on their ability to pay and garner payments from patients’ insurance companies. Air
47 ambulance providers typically charge standard rates based on an established lift-off fee and per
48 mile fee for all transports and receive payments from various sources at differing rates depending
49 on a patient’s insurance coverage. Further, the amount paid by private health insurance hinges on
50 whether the air ambulance provider participates in a contract with the private insurer.

1 Depending on insurance coverage, patients can be billed for air ambulance charges that have
2 potentially significant financial consequences. Costs for the average air ambulance trip run in the
3 tens of thousands of dollars. According to the Centers for Medicare & Medicaid Services (CMS)
4 and private health insurance data, between 2010 and 2014, the median prices providers charged for
5 air ambulance service doubled from about \$15,000 to about \$30,000 per transport.⁹ According to
6 numerous air ambulance providers, privately insured patients account for the largest percentage of
7 their revenue. The median payment that three large national private insurers paid per air ambulance
8 transport increased from about \$15,600 to \$26,600 from 2010 to 2014, an increase of 70 percent.
9 With insurers under pressure to cut costs, they have been reducing payments for air ambulances.¹⁰

10
11 Although air ambulances account for less than one percent of total ambulance claims, they
12 represent about eight percent of Medicare spending on ambulance services due to their significant
13 cost. Air ambulance providers are not permitted to balance bill Medicare and Medicaid patients
14 beyond deductibles and coinsurance requirements. Patients with private insurance may be balance
15 billed only if the air ambulance provider is out-of-network. Patients without insurance may be
16 billed for the total price of the air ambulance bill. Due to a lack of information, it is unclear to what
17 extent air ambulance providers balance bill.

18
19 Numerous factors likely contribute to the high costs of air ambulance services, including the price
20 and maintenance of the necessary equipment and employment of specialized medical personnel
21 around-the-clock. In order to stay in operation, air ambulance providers must earn revenue
22 sufficient to cover their costs. The median cost per base for independent air programs is almost
23 \$3 million, with 77 percent of the costs incurred being fixed costs associated with operating a
24 base.¹¹ To increase revenue, air ambulance providers need to increase the number of transports or
25 the cost charged per transport. According to eight air ambulance providers, the average cost they
26 incurred per transport is between \$6,000 to \$13,000.¹²

27
28 A more thorough look into the factors affecting air ambulance pricing is not possible due to lack of
29 data. For example, the cost incurred by air ambulance providers to provide service is not readily
30 available, and there is no national database with this information. Moreover, there are no data
31 available that address cost differences of air ambulance service capabilities and how cost is affected
32 not only by transport but also service level. In addition, available data are insufficient to discern the
33 prices charged by air ambulances, charges across various air ambulance business models, and
34 charges to individuals with varying coverage statuses. The lack of systematic data collection makes
35 it impossible to determine the market share of particular air ambulance providers and corresponding
36 price information.

37 38 LEGISLATIVE ACTIVITY

39
40 Though some states have attempted to create consumer protections from costly air ambulance bills,
41 federal preemption has largely prevented state regulation. The Airline Deregulation Act (ADA) of
42 1978 prohibits states from regulating the price, route, or service of an air carrier for the purposes of
43 keeping national commercial air travel competitive.¹³ The ADA applies to air carriers that provide
44 air ambulance services and are, therefore, protected from state attempts to regulate their price,
45 route, and service. Accordingly, air ambulance providers generally are not subject to the price
46 competition that usually occurs in competitive markets wherein high prices will lead consumers to
47 find lower-cost alternatives.

1 In contrast to air ambulances, ground ambulances are regulated under the Affordable Care Act
2 (ACA) and applicable state laws.¹⁴ However, for air ambulances, such protections are applied only
3 with the model in which the ambulance service is affiliated with the hospital and, therefore,
4 considered an extension of the emergency department service.

5
6 Numerous states have attempted to pass legislation to protect consumers from out-of-network air
7 ambulance bills; however, these laws have been preempted by the ADA.¹⁵ Federal legislation is
8 necessary in order to give states the authority to address the issue. Generally, state insurance
9 regulators support legislation allowing states the flexibility to protect consumers from excessive
10 out-of-network charges. Regulators have shown a willingness to regulate how air ambulance
11 carriers are paid, participate in networks, balance bill, and make information transparent to
12 consumers.

13 14 RELEVANT AMA POLICY

15
16 Policy H-285.904 includes principles related to unanticipated out-of-network care and states that
17 patients must not be financially penalized for receiving unanticipated care from an out-of-network
18 provider, insurers must meet appropriate network adequacy standards, and patients seeking
19 emergency care should be protected under the “prudent layperson” legal standard. Similarly,
20 Policy D-130.975 advocates that insurers pay for EMTALA services regardless of in-network and
21 out-of-network status.

22
23 Policy D-130.989 states that legislation and regulation should be used to require all health payers to
24 cover emergency services. Policy H-130.970 promulgates principles on access to emergency
25 services and states that all physician and health care facilities have an ethical and moral
26 responsibility to provide needed emergency services to all patients, regardless of their ability to
27 pay. Importantly, the policy notes that health plans should educate enrollees regarding the
28 appropriate use of emergency facilities. Similarly, Policy H-130.954 supports the education of
29 physicians and the public about the costs of inappropriate use of emergency patient transportation
30 systems and encourages the development of non-emergency patient transportation systems that are
31 affordable to the patient, thereby ensuring cost effective and accessible health care. Moreover,
32 Policy H-130.970 states that all health plans should be required to cover emergency services
33 provided by physicians and hospitals to plan enrollees without regard to prior authorization or the
34 emergency care physician’s contractual relationship with the payer. The policy also encourages
35 states to enact legislation holding health plans and third-party payers liable for patient harm
36 resulting from any restrictions on the provision of emergency services. Policy D-130.975 similarly
37 states that all insurers should be required to assign payments directly to any health care provider
38 who has provided EMTALA-mandated emergency care, regardless of network status.

39
40 Policy H-240.978 supports changes in Medicare regulations governing ambulance service coverage
41 guidelines that would expand the term “appropriate facility” to allow full payment for transport to
42 the most appropriate facility based on the patient’s needs and the determination made by physician
43 medical direction. The policy goes on to state that the AMA will work with CMS to pay emergency
44 medical service providers for the evaluation and transport of patients to the most appropriate site of
45 care not limited to the current CMS defined transport locations.

46
47 To promote the safety of emergency medical service helicopters, Policy D-130.967 highlights the
48 importance of the Federal Aviation Administration’s Helicopter Medical Service Operations and
49 Safety Alert for Operators and its role as a critical component of Helicopter Emergency Medical
50 Services in assuring the safety of patients and medical providers. The policy goes on to advocate
51 that its members contract with or implement a Helicopter Emergency Medical Service that is

compliant with risk reduction systems/programs established in standards set forth in the Federal Aviation Administration's Helicopter Medical Service Operations and Safety Alert for Operators.

DISCUSSION

Air ambulances serve to reduce the transit time for critically ill patients in emergent circumstances. Due to the nature of air ambulance services, patients typically have little or no choice over their mode of transportation and the provider of such transportation and can face significant air ambulance bills.

To address the appropriate provision of emergency care and consistent with ethical delivery of care, the Council recommends amending Policy H-130.954 not only to support the education of physicians and the public, but also first responders, about the costs associated with inappropriate use of emergency patient transportation systems and encouraging the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

Many aspects of the air ambulance market and the extent patients are balance-billed are unclear due to lack of available data. There is a void in data on ownership, revenue, and service capabilities. Similarly, data on the costs to provide service, the number of transports, and provider information are not readily available. For example, it is unclear whether price increases are tied to market concentration or whether providers adjust prices to receive sufficient revenue from private insurance to account for lower-paid transports, such as those paid for by Medicare. Moreover, there is evidence that in markets with predominantly hospital-owned air ambulance providers, patients are balance-billed at lower rates and face lower costs. However, because these data cannot be verified at this time, the Council believes it is most appropriate to support increased data collection and data transparency of air ambulance providers and services, particularly increased price transparency. Subsequently, the Council recommends supporting consumer disclosures that include price variation among air ambulance providers and the potential limits of insurance coverage.

As previously discussed, the ADA preempts state-level regulation of air ambulance prices, routes, and services. Due to a profound void in air ambulance data, the Council believes that calling for an amendment to the ADA is premature. Before such a recommendation could even be considered, the Council believes that requisite information is needed on air ambulance command and control practices as well as additional data to determine the root cause of the issue at hand, and whether it is a result of market failure or other causes. Therefore, the Council strongly calls for additional data collection and transparency on air ambulances and sees merit in working with relevant stakeholders to evaluate the ADA as it applies to air ambulances.

The AMA believes that access to affordable emergent health care services must be preserved and strengthened. In that spirit, the Council recommends supporting the sharing of industry best practices among stakeholders across various regions. The Council's recommendations build upon the AMA's work to improve safe and affordable air ambulance access and protect patients in life-threatening emergencies.

RECOMMENDATIONS

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

- 1 1. That our American Medical Association (AMA) amend Policy, H-130.954, “Non-
2 Emergency Patient Transportation Systems,” by addition as follows:
3 The AMA: (1) supports the education of physicians, first responders, and the public about
4 the costs associated with inappropriate use of emergency patient transportation systems;
5 and (2) encourages the development of non-emergency patient transportation systems that
6 are affordable to the patient, thereby ensuring cost effective and accessible health care for
7 all patients. (Modify Current HOD Policy)
8
- 9 2. That our AMA support increased data collection and data transparency of air ambulance
10 providers and services to the appropriate state and federal agencies, particularly increased
11 price transparency. (New HOD Policy)
12
- 13 3. That our AMA work with relevant stakeholders to evaluate the Airline Deregulation Act as
14 it applies to air ambulances. (New HOD Policy)
15
- 16 4. That our AMA support stakeholders sharing air ambulance best practices across regions.
17 (New HOD Policy)
18
- 19 5. That our AMA rescind Policy D-130.964, which directed the AMA to conduct the study
20 herein. (Rescind AMA Policy)

Fiscal Note: Less than \$500.

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⁴ Air Ambulances. National Association of Insurance Commissioners. January 2018. Available at: https://www.naic.org/cipr_topics/topic_air_ambulances.htm

⁵ Vercruysse, GA, et al. Overuse of Helicopter Transport in the Minimally Injured: A Health System Problem that Should be Corrected. Journal of Trauma and Acute Care Surgery. 2015. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25710420>

⁶ Sherlock, Richard. Protect Air Ambulance Services that Fill the Health Care Access Gap in Rural America. The Hill. May 2018. Available at: <http://thehill.com/blogs/congress-blog/healthcare/389347-protect-air-ambulance-services-that-fill-the-health-care>

⁷ *Supra* note 1.

⁸ Up in the Air: Inadequate Regulation for Emergency Air Ambulance Transportation. Consumers Union. March 2017. Available at: <https://consumersunion.org/wp-content/uploads/2017/04/Up-In-The-Air-Inadequate-Regulation-for-Emergency-Air-Ambulance-Transportation.pdf>

⁹ *Supra* note 1.

¹⁰ *Id.*

¹¹ Air Medical Services Cost Study Report. Prepared for: The Association of Air Medical Services and Members. March 2017. Available at: <http://aams.org/wp-content/uploads/2017/04/Air-Medical-Services-Cost-Study-Report.pdf>

¹² *Supra* note 1.

¹³ Air Ambulances. National Association of Insurance Commissioners. January 2018. Available at: https://www.naic.org/cipr_topics/topic_air_ambulances.htm

¹⁴ *Id.*

¹⁵ *Id.*

REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (I-18)
The Site-of-Service Differential
(Resolution 817-I-17)
(Reference Committee J)

EXECUTIVE SUMMARY

The site-of-service differential is a longstanding payment policy issue stemming from the Medicare program's use of separate payment systems in its rate-setting calculations. This report addresses disparities in Medicare Part B payment for covered items and services across outpatient care settings, including the offices of physicians and other health professionals, hospital outpatient departments (HOPDs), and ambulatory surgical centers (ASCs). Most outpatient procedures can be provided across multiple clinical settings, and although the choice of outpatient site for many services has no discernible effect on patient care, it significantly impacts Medicare's payment for such services and patient cost-sharing expenses. Generally speaking, Medicare pays higher rates for outpatient services performed in hospital facilities than to physician offices or ASCs for furnishing the same service to similar patients. The scope of the payment differential varies, depending on the procedure.

This report describes ongoing disparities in Medicare payment for outpatient procedures across care settings, explains how Medicare determines payments for outpatient services in each setting, compares Medicare physician payment updates to inflation, and summarizes relevant American Medical Association (AMA) policy and activity. The Council recommends reaffirmation of existing AMA policy as well as new policy addressing the site-of-service differential. The Council recommends that the AMA support Medicare payment policies for outpatient procedures that are site-neutral without lowering total Medicare payments. The Council further recommends that the AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting.

While the focus of this report is the site-of-service differential, the Council recognizes that broader physician payment issues must also be addressed. To help build the case for future Medicare payment reforms that support site-neutrality without lowering total Medicare payments, the Council recommends that the AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-18

Subject: The Site-of-Service Differential
(Resolution 817-I-17)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

At the 2017 Interim Meeting, the House of Delegates referred Resolution 817-I-17, “Addressing the Site of Service Differential,” introduced by the New Mexico Delegation, for report back at the 2018 Annual Meeting. The Board of Trustees assigned this item to the Council on Medical Service. Resolution 817-I-17 asked the American Medical Association (AMA) to:

- 1) Study the site-of-service differential with a report back no later than the 2018 Interim Meeting, including: a) the rising gap between independent practice expenses and Medicare reimbursement, taking into account the costs of the regulatory requirements; b) the increased cost of medical personnel and equipment, including electronic health record (EHR/EMR) purchase, software requirements, and ongoing support and maintenance; c) the expense of maintaining hospital-based facilities not common to independent practices, such as burn units and emergency departments, and determine what payment should be provided to cover those explicit costs; and d) the methodology by which hospitals report their uncompensated care, and the extent to which this is based on actual costs, not charges; and
- 2) Advocate for a combined health care payment system for patients who receive care that is paid for by the Centers for Medicare & Medicaid Services (CMS), that: a) follows the recommendation of MedPAC to pay “site-neutral” reimbursement that sufficiently covers practice expenses without regard to whether services are performed under the Hospital Outpatient Prospective Payment System (OPPS) or the Physician Fee Schedule (PFS); b) pays appropriate facility fees for both hospital owned facilities and independently owned non-hospital facilities, computed using the real costs of a facility based on its fair market value; and c) provides independent practices with the same opportunity to receive reimbursement for uncompensated care as is provided to hospital owned practices.

This report describes ongoing disparities in Medicare payment for outpatient procedures across care settings, summarizes relevant AMA policy and activity, and presents policy recommendations addressing the outpatient site-of-service differential.

BACKGROUND

The site-of-service differential is a longstanding payment policy issue stemming from the Medicare program’s use of more than a dozen separate payment systems—some of which are based on the location where services are provided—in its rate-setting calculations. Several of these payment systems base payments on the location where services are provided. This report addresses disparities in Medicare Part B payment for covered items and services across outpatient care

settings, including the offices of physicians and other health professionals, hospital outpatient departments (HOPDs), and ambulatory surgical centers (ASCs). Most outpatient procedures can be provided across multiple clinical settings, and although the choice of outpatient site for many services has no discernible effect on patient care, it significantly impacts Medicare’s payment for such services and patient cost-sharing expenses. Generally speaking, Medicare pays higher rates for outpatient services performed in hospital facilities than to physician offices or ASCs for furnishing the same service to similar patients. The scope of the payment differential varies, depending on the procedure, and in some cases may be difficult to ascertain because units of payment differ across payment systems. Furthermore, the payment differential may extend beyond primary services to entire episodes of care. One analysis found that payments for cardiovascular imaging, colonoscopy, and evaluation and management services are higher when furnished in HOPDs, and that the higher payments extend to related services provided to patients as part of episodes of care associated with these procedures.¹ The variations in payment persisted after controlling for patient demographic and severity differences, thereby attributing a substantial portion of the pay disparities to the payment systems themselves.²

The Council previously studied aspects of the site-of-service differential—and confirmed that Medicare payments for many procedures are higher when furnished in HOPDs—during the development of Council Report 3-A-13, “Payment Variations across Outpatient Sites of Service,” and Council Report 3-A-14, “Medicare Update Formulas Across Outpatient Sites of Service.” Council Report 3-A-13 compared Medicare payments for five common procedures performed across outpatient settings, and built upon the AMA’s substantial policy supporting site neutrality by encouraging private payers to incentivize outpatient care delivery in lower-cost settings. Council Report 3-A-14 found that existing Medicare payment formulas have contributed to growth in the volume of outpatient services provided in hospitals and hospital-owned facilities, even when these services can be safely performed in lower-cost settings. Council Report 3-A-14 focused primarily on equalizing payments between HOPDs and ASCs because payments to these settings are based on the same Medicare payment system (OPPS), with ASCs paid at lower rates. Developing policy addressing payment disparities between hospital-owned facilities and independent physician practices is more complex because, under current statute, the rate-setting for items and services in these outpatient sites is based on separate Medicare payment systems that calculate payments for different units of service.

Medicare Payment Rates for Off-Campus Provider-Based Hospital Departments

For many years, higher payments to HOPDs likely incentivized the sale of physician practices and ASCs to hospitals because acquired facilities meeting certain criteria (eg, located within 35 miles of the hospital) were routinely converted to HOPDs and allowed to charge higher OPPS rates for services performed at these off-campus facilities. However, a provision in the Bipartisan Budget Act of 2015 (BBA) disallowed provider-based billing by hospitals for newly acquired physician practices and ASCs. The Congressional Budget Office estimated in 2015 that this provision would save \$9.3 billion over 10 years.³ Beginning in 2017, off-campus entities acquired after enactment of the BBA—in November 2015—were no longer permitted to bill for services under the OPPS, and instead required to bill under the applicable payment system (PFS). Since 2017, CMS has paid for services at non-excepted off-campus provider-based hospital departments using a PFS relativity adjuster that is based on a percentage of the OPPS payment rate. Currently, CMS regulations stipulate that these services be paid 40 percent of OPPS payment rates,⁴ although provider-based departments acquired prior to November 2015 continue to bill under the OPPS. In July 2018, CMS proposed extending site-neutral payments to include clinic visits provided at off-campus provider-based hospital departments acquired prior to November 2015, that were excepted from the BBA provision.⁵ CMS proposed to reduce payment rates for clinic visits at hospital-owned physician

practices located off the hospital campus from \$116 with \$23 cost-sharing to \$46 with \$9 cost-sharing.⁶ At the time this report was written, the CMS proposal had not been finalized.

Hospital Employment of Physicians

It is possible that Medicare payment reductions for services provided at off-campus provider-based hospital departments acquired after November 2015 have contributed to a leveling off of hospital acquisitions of physician practices. Data from the AMA's 2012, 2014, and 2016 Physician Practice Benchmark Surveys, which yield nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week, demonstrate recent stability in the ownership structure of physician practices. Analyses of the surveys found that the share of physicians who worked directly for a hospital or in practices that were at least partially owned by a hospital remained unchanged between 2014 and 2016—at 33 percent.⁷ This percentage represented an increase from 29 percent in 2012. Although detailed information on practice ownership structure is not available for years prior to 2012, research suggests that in 2007-2008, only 16 percent of physicians worked directly for a hospital or in practices that were at least partially owned by a hospital.⁸

Medicare Payment Systems for Outpatient Services

The separate methodologies used for rate-setting under the OPPTS 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 OPPTS and PFS payment systems, Medicare may pay dramatically different rates for the same services based on whether they are provided in hospital facilities or physician offices.

Table 1: Medicare Payment Systems for Physician Offices, Hospital Outpatient Departments, and Ambulatory Surgical Centers

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

For services furnished in physician and other practitioner offices, Medicare pays for units of service billed under the PFS. There is a single payment for each service which amounts to 80 percent of the PFS rate, with the patient responsible for cost-sharing that covers the remaining 20 percent. For procedures provided in hospital outpatient departments, Medicare pays a reduced physician fee under the PFS plus a facility fee established under the OPPTS. 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 OPPTS

are grouped together into ambulatory payment classifications based on clinical and cost similarities.

Formulas unique to each payment system are then used to annually adjust payment rates for inflation, which may actually widen existing payment disparities. HOPD updates are based on the hospital market basket, and annual updates to the PFS were established by MACRA. The Medicare program currently uses the consumer price index for all urban consumers (CPI-U) to annually update ASC payment rates, although—consistent with AMA policy—CMS recently proposed updating ASC rates using the hospital market basket instead of the CPI-U for a five-year period. If this proposal is finalized, CMS will examine whether the change incentivizes a migration of services to lower-cost ASC settings over the five-year period.

Medicare Physician Payment Updates Compared to Inflation

Medicare payments for physician services have for many years failed to keep pace with the actual costs of running a practice. From 2001 to 2017, Medicare physician pay rose just six percent (0.4 percent per year on average), although Medicare's index of inflation in the cost of running a practice increased 30 percent (1.7 percent per year on average). Economy-wide inflation, as measured by the Consumer Price Index, has increased 39 percent over this time period.⁹ Adjusted for inflation in practice costs, Medicare physician pay has declined 19 percent from 2001 to 2017, or by 1.3 percent per year on average.

During the same time period, Medicare hospital pay has increased roughly 50 percent, with average annual increases of 2.6 percent per year for inpatient services, and 2.5 percent per year for outpatient services. Medicare skilled nursing facility pay has increased 51 percent between 2001 and 2017, or 2.6 percent per year.¹⁰ There are some significant differences between hospitals and physician practices that may lead to higher costs of providing care in HOPDs. For example, hospitals maintain operations 24/7, and also standby capacity for handling emergencies, although payment for standby costs is included in Medicare's payment for emergency department services.¹¹

Uncompensated/Inadequately Compensated Physician Practice Expenses

The need for sustainable physician payments under the Medicare program is compounded by numerous uncompensated administrative tasks that are extremely costly to practices and reduce time spent with patients, yet increase the work necessary to provide medical services. CMS alone publishes thousands of pages of regulations affecting physician practices every year, including rules governing the reporting of quality measures, the Recovery Audit Contractor (RAC) Program, MACRA implementation, and Medicare's numerous payment systems. Utilization management has become so burdensome that in 2017 the average physician reported completing 29 prior authorizations per week, a process that required 14.6 hours of work or the equivalent of two business days.¹² In addition to navigating a plethora of payer protocols and utilization management requirements, physician practices have to purchase, manage and update electronic health records (EHRs) to document the care they are providing. Incorporating EHR technology into practice workflows is costly and consumes a significant amount of physician time that could otherwise be spent with patients. Notably, a 2016 *Annals of Internal Medicine* study found that, for every hour of clinic time spent with patients, physicians spend approximately two hours per day during office hours, and another one to two hours outside of office hours, on EHR and desk work.¹³ According to a 2016 *Health Affairs* study, physician practices across four common specialties spend over \$15.4 billion annually to report quality measures, with physicians on average spending 2.6 hours per week on these measures.¹⁴ Many physician practices also provide high-technology outpatient

1 services (ie, infusions and/or imaging) that were once the domain of hospitals and for which
2 practices are not adequately compensated under the PFS.

3
4 Hospitals that treat a disproportionate share of low-income patients receive additional payments to
5 offset the financial effects of treating these patients. Traditionally, disproportionate share hospital
6 (DSH) payments were based on hospitals' share of Medicaid patients and Medicare patients with
7 Social Security Disability Insurance. Beginning in 2014, DSH payments were calculated as 25
8 percent of that payment amount, and hospitals also began receiving uncompensated care payments
9 from a pool of funds equal to 75 percent of the DSH payment received under the traditional
10 formula, minus an amount that increases in proportion to decreases in the uninsured population.¹⁵
11 Part of this pool is distributed to hospitals based on the share of uncompensated care they
12 provide.¹⁶ Physician practices are not eligible for either DSH or uncompensated care payments,
13 despite the fact that most physicians (89 percent) treat Medicare patients and, in 2016, most also
14 had Medicaid (82.6 percent) and uninsured (75.6 percent) patients.¹⁷ There have been questions as
15 to whether Medicare DSH and uncompensated care payments are appropriate proxies for the
16 amount of uncompensated care provided by hospitals, and Medicare Payment Advisory
17 Commission (MedPAC) has recommended that uncompensated care payments to hospitals be
18 based on actual uncompensated care data.

19
20 *Expert Policy Recommendations for Reducing Payment Variations*

21
22 To address shifts in outpatient care to higher cost sites-of-service (eg, hospital-owned facilities),
23 which increase costs to the Medicare program and its patients, several policy options have been
24 proposed to equalize payments across settings for certain services. After the MedPAC found that
25 payments to HOPDs for 15-minute evaluation and management visits were 80 percent higher than
26 payments to physician offices for the same service, it recommended in 2012 that HOPD payments
27 for these services be reduced to physician office rates.¹⁸ In 2014, MedPAC recommended that
28 differences in payment rates between HOPDs and physician offices be eliminated by reducing
29 HOPD rates for 66 ambulatory payment classifications. These groups of services were selected by
30 MedPAC based on patient severity being similar in HOPDs and physician offices, and because they
31 are frequently furnished in physician offices.¹⁹

32
33 A 2011 RAND Health analysis examined several policy options for addressing Medicare payment
34 differentials across outpatient sites, such as increasing uniformity in the units of service across
35 payment systems, and basing payment rates on the least costly setting. This analysis concluded that
36 basing payment differentials on justifiable cost differences would promote payment equity across
37 outpatient sites-of-care and value-based care, but would also be administratively burdensome.
38 Determining justifiable cost differences would also be impractical.²⁰

39
40 The Office of the Inspector General (OIG) has also recommended reductions in HOPD payment
41 rates to those of less costly settings, and has even recommended pursuing legislative changes to
42 OPPI budget neutrality provisions so that payment rates to HOPDs could be reduced without
43 offsetting those reductions with payment increases.²¹ Several administrations have also proposed
44 equalizing payment variations via budget proposals, and President Trump's budget published in
45 February 2018 proposed applying physician office rates to all hospital-owned physician offices
46 located off the hospital campus. As stated previously, CMS has proposed extending site-neutral
47 payments to include clinic visits provided at off-campus hospital-owned facilities.

48
49 It is clear that most of the policy options identified to date have recommended leveling the site-of-
50 service playing field by reducing payment rates to the amounts payable in the least costly
51 outpatient setting. Although CMS has not implemented the MedPAC or OIG recommendations, in

2014 the agency identified approximately 200 services for which physician office payments were higher than HOPD or ASC rates and proposed lowering physician fees for these services. Most experts, including MedPAC, believe that Medicare payments to physician offices, HOPDs and ASCs will continue to be based on the program's current payment systems for the foreseeable future. The combined payment system called for in the second resolve of Resolution 817-I-17 would require legislative changes that would face significant obstacles in a Congress that is hamstrung by partisanship and budgetary concerns. Opponents, including hospitals and other stakeholders whose payment rates would be affected, are likely to counter that physicians' facility costs are already covered through the practice expense component of the PFS.

Moreover, convincing Congress to redesign Medicare's payment systems would be extremely difficult. Given existing pressures to reduce health care costs, there is also a risk that advocating for a combined payment system could encourage Congress or CMS to design a system that lowers payments to all providers and/or does not provide relief for independent physician practices. CMS could also choose to impose the OPFS payment system, on which HOPD and ASC payments are based, on physician practices. Doing so would mean that units of service currently paid separately under the PFS would be grouped together into an ambulatory payment classification, which is the unit of payment under the OPFS.

Updating Physician Practice Expenses Paid under the PFS

Alternatively, the Council considered requesting that CMS update the inputs used to calculate the indirect practice expense component of the PFS, which is analogous to OPFS facility fees and which is based in part on 10-year-old survey data that no longer reflect current practice arrangements or the relative costs of running a practice. Updated data are urgently needed to ensure that practice expenses under the PFS more accurately reflect the costs to physician practices of furnishing office-based services. However, it is important to recognize that any practice expense changes under the current system will need to be budget neutral.

Payments under the PFS are required by statute to be based on national uniform relative value units (RVUs) that account for the relative resources used in furnishing a service.²² In brief, RVUs are established for work, practice expense, and malpractice expense categories, which are adjusted for geographic cost variations. These values are multiplied by a conversion factor to convert the RVUs into payment rates. Statutory budget neutrality provisions require that annual adjustments to the RVUs that increase by more than \$20 million must be offset by cuts in other RVUs or through a cut in the conversion factor.²³

CMS establishes separate facility-and nonfacility-based practice expense RVUs for services furnished in facility settings (eg, HOPD or ASC) and in nonfacility settings (eg, physician offices). Facility-based RVUs are generally lower than nonfacility-based RVUs, so that HOPDs and ASCs receive facility payments under the OPFS whereas physician offices receive a facility fee under the PFS. Nonfacility practice expense RVUs are intended to reflect all of the direct and indirect practice expenses associated with furnishing a service in a physician office.

Direct expenses include cost inputs related to clinical labor, medical equipment and supplies. Indirect expenses include administrative labor, rent, billing services, and other office-related expenses that cannot be directly attributed to a service. In its proposed rule for CY 2019, CMS proposed updated pricing recommendations for 2,017 supply and equipment items currently used as direct practice expense inputs. The proposal is based on a report from a CMS contractor that used market research resources and methodologies to determine the updated prices.²⁴ As described in the following section, survey data are used by CMS to determine the indirect practice expenses

1 incurred per hour worked.²⁵ Each procedure is then assigned practice expense RVUs that are
2 supposed to reflect the practice expenses required to provide the service relative to those required
3 to provide other procedures.

4
5 The need for accurate data on practice costs is significant, considering many of the points raised in
6 Resolution 817-I-17. Physician practices have experienced significant increases in practice
7 expenses due to cumbersome regulations, quality measure requirements, EHRs (purchases,
8 software upgrades, ongoing support and maintenance), complex payment and utilization
9 management protocols, costly equipment used to provide, for example, imaging or infusions, and
10 other costs that have changed dramatically since practice expense survey data was collected a
11 decade ago. It may also be challenging for many independent and small group practices to
12 accurately determine their total practice expenses when completing surveys about the costs of
13 running a practice.

14 15 *The Physician Practice Information Survey (PPI Survey)*

16
17 In 2010, CMS began basing indirect practice expenses on the PPI Survey, a multispecialty,
18 nationally representative survey of both physicians and non-physician practitioners paid under the
19 PFS that was administered by the AMA over a period of time in 2007 and 2008. The PPI Survey
20 collected data from 3,656 respondents across 51 medical specialties and health care professional
21 groups.²⁶ Participating practices were asked to fill out expense worksheets that itemized expenses
22 such as payroll, supplies and equipment. They were also asked about the costs of managing a
23 practice, charity care, time spent on quality improvement activities, and the acquisition, operating
24 and maintenance costs associated to EHRs. PPI Survey data were used by CMS to confirm the
25 accuracy of PFS practice expense data. As required by statute, CMS uses medical oncology
26 supplemental survey data from 2003 for practice expenses per hour for oncology drug
27 administration services. For specialties that did not participate in the PPI Survey, CMS develops
28 proxy practice expense values by crosswalking practice expense data from specialties providing
29 similar services.²⁷

30
31 Section 220 of the Protecting Access to Medicare Act of 2014, allocates funds for CMS "...to
32 collect and use information on physicians' services in the determination of relative values in the
33 formulae for setting physician's fees."²⁸ The AMA/Specialty Society RVS Update Committee and
34 other entities have encouraged CMS to use these funds to conduct an updated survey on practice
35 expense data. Even CMS has expressed concerns regarding the accuracy of the outdated data used
36 to determine practice expense RVUs but, lacking other sources, the agency continues using PPI
37 Survey data to inform physician payments under the PFS. The collection of physician practice
38 expense data is a necessary first step which will enable comparisons to hospital cost and payment
39 metrics and provide insight into the costs of care provided in hospital-owned and independently-
40 owned practices.

41 42 **AMA POLICY**

43
44 The AMA has substantial and long-standing policy supporting equitable payments across
45 outpatient sites of service. Policy H-240.993 calls for equity of payment between services provided
46 by hospitals on an outpatient basis and similar services in physicians' offices. AMA policy also
47 supports defining Medicare services consistently across settings and encouraging the CMS to adopt
48 payment methodologies that assist in leveling the playing field across all sites of service (Policy
49 D-330.997).

1 Policy H-330.925 encourages CMS to fairly pay physicians for office-based procedures and adopt
2 a site-neutral payment policy for hospital outpatient departments and ambulatory surgical centers;
3 advocates for the use of valid and reliable data in the development of any payment methodology
4 for the provision of ambulatory services; advocates that in place of the CPI-U, CMS use the
5 hospital market basket index to annually update ASC payment rates; and encourages the use of
6 Current Procedural Terminology (CPT) codes across all sites of service as the only acceptable
7 approach to payment methodology.

8
9 Policy H-400.957 encourages CMS to expand the extent and amount of reimbursement for
10 procedures performed in the physician office, to shift more procedures from the hospital to the
11 office setting, which is more cost effective, and to seek to have practice expense RVUs reflect the
12 true cost of performing office procedures. Policy H-400.966 directs the AMA to aggressively
13 promote the compilation of accurate data on all components of physician practice costs, and the
14 changes in such costs over time, as the basis for informed and effective advocacy concerning
15 physician payment under Medicare.

16
17 Policy D-240.994 directs the AMA to work with states to advocate that third-party payers be
18 required to assess equal or lower facility coinsurance for lower-cost sites of service; publish and
19 routinely update pertinent information related to patient cost-sharing; and allow their plan's
20 participating physicians to perform outpatient procedures at an appropriate site of service as chosen
21 by the physician and the patient. Furthermore, AMA policy urges private third-party payers to
22 implement coverage policies that do not unfairly discriminate between hospital-owned and
23 independently owned outpatient facilities with respect to payment of facility costs (Policy
24 H-240.979). Policy H-390.849 directs the AMA to advocate for the adoption of physician payment
25 reforms that promote improved patient access to high-quality and cost-effective care, do not require
26 budget neutrality within Medicare Part B, and are based on payment rates that are sufficient to
27 cover the full cost of sustainable medical practices.

28 29 AMA ACTIVITY

30 31 *Enhancing Practice Efficiency and Promoting Physician Satisfaction*

32
33 A strategic focus area within the AMA is working diligently to help physicians succeed in a rapidly
34 changing health care environment. From advancing health care delivery and payment reforms that
35 promote affordable care to restoring and preserving physician professional satisfaction, the AMA is
36 driving practice transformation by translating regulatory requirements into actionable information;
37 developing and disseminating practice improvement strategies and tools; establishing national
38 benchmarks for physician burnout, leading to organizational level changes; and producing
39 evidence-based research. To accelerate advancements in—and support for—physician and care
40 team well-being, the AMA sponsors conferences that bring top investigators and thought leaders
41 together to debate and advance health policies.

42 43 *Encouraging Value-Based Payment*

44
45 The AMA has been working for several years to encourage the development and implementation of
46 Medicare payment models that will improve the financial viability of physician practices in all
47 specialties, and help independent practices of all sizes remain independent; give physicians more
48 resources and greater flexibility to deliver appropriate care to their patients; minimize
49 administrative burdens that do not improve the quality of patient care; enable physicians to help
50 control aspects of health care spending that they can influence, rather than having Medicare use
51 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.²⁹ 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.³⁰

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.

1 Building on these policies, the Council recommends that the AMA support Medicare payment
2 policies for outpatient services that are site-neutral without lowering total Medicare payments. This
3 policy recommendation enables ongoing AMA advocacy in support of site-neutral payments while
4 at the same time seeking solutions that do not simply lower payments for services to amounts paid
5 to the least costly setting. The Council is mindful that there is the potential for physicians to be
6 adversely affected as Congress and the Administration promote site-neutrality based solely on cost
7 as a means of reining in health care spending.

8
9 The site-of-service differential impedes the provision of high-value care because it incentivizes
10 payment based on the location where a service is provided. Payment should be based on the service
11 itself, and not the location where it is provided. Accordingly, the Council recommends that the
12 AMA support Medicare payments for the same service routinely and safely provided in multiple
13 outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and
14 accurate data regarding the real costs of providing the service in each setting.

15
16 After extensive exploration of the “combined health care payment system” described in the second
17 resolve of Resolution 817-I-17, the Council concludes that the practice expense component of the
18 PFS is analogous to the facility fee paid under the OPPOS, and that the valuation of the practice
19 expense component needs to be updated to accurately reflect the costs of running a practice. The
20 Council further believes that if physicians are paid a facility fee as called for in the second resolve,
21 that fee is likely to be smaller than the current one and might not make up for the probable
22 elimination of the practice expense differential in the current system. Rather than seeking the
23 statutory changes to implement a combined payment system that pays facility fees for both
24 hospital-owned and independent physician practices—which would be extremely challenging to
25 accomplish in a Congress hamstrung by partisanship and a trillion-dollar deficit—the Council
26 recommends urging CMS to update the data used to calculate the practice expense component of
27 the PFS. The Council believes that CMS should conduct a survey similar to the PPI Survey to
28 confirm the accuracy of practice expense data, given the many changes that have occurred since the
29 survey was administered in 2007 and 2008, and that this survey should be administered every five
30 years to ensure that timely data are used to inform PFS calculations. The Council believes that
31 CMS should collect data to ensure that all physician practice costs are captured. Examples of data
32 that must be collected by CMS include administrative and other costs that cannot be directly
33 attributed to a service, costs of managing the practice, costs of providing uncompensated care, costs
34 of navigating payer protocols and utilization management requirements, costs of purchasing,
35 managing and updating EHRs, and costs related to quality measures and improvements.

36
37 Advocating for regular ongoing collection of physician practice expense data that more accurately
38 reflect the costs of sustaining a practice is a viable option that could be impactful in the nearer term
39 although, under Medicare’s current system, PFS payments would be redistributed rather than
40 increased overall. The updated data could be used to help measure differences in the costs of
41 providing services in physician offices and hospital settings, and would inform future AMA
42 advocacy on broader payment reforms.

43
44 To address concerns regarding the methodology used for DSH and uncompensated care payments
45 to hospitals and the care provided by many physicians for which they are not fully compensated,
46 the Council recommends that the AMA encourage CMS to both: a) base DSH and uncompensated
47 care payments to hospitals on actual uncompensated care data; and b) study the costs to
48 independent physician practices of providing uncompensated care.

49
50 While the focus of this report is the site-of-service differential, the Council recognizes the need to
51 address broader physician payment issues. The Council further recognizes that achieving site-

neutral payments for outpatient procedures will require increases in Medicare payment for physician services so that physician practices can be sustained and patient choice of care setting is safeguarded. To help build the case for future Medicare payment reforms, the Council recommends that the AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 817-I-17, and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-240.993, which urges more aggressive implementation by the US Department of Health and Human Services of existing provisions in federal legislation calling for equity in payment between services provided by hospitals on an outpatient basis and similar services in physician offices. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy D-330.997, which encourages the Centers for Medicare & Medicaid Services (CMS) to define Medicare services consistently across settings and adopt payment methodology for hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) that will assist in leveling the playing field across all sites-of-service. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy H-400.957, which encourages CMS to expand the extent and amount of reimbursement for procedures performed in the physician office, to shift more procedures from the hospital to the office setting, which is more cost effective, and to seek to have practice expense relative value units reflect the true cost of performing office procedures. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-400.966, which directs the AMA to aggressively promote the compilation of accurate data on all components of physician practice costs, and the changes in such costs over time, as the basis for informed and effective advocacy concerning physician payment under Medicare. (Reaffirm HOD Policy)
5. That our AMA support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. (New HOD Policy)
6. That our AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting. (New HOD Policy)
7. That our AMA urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured. (New HOD Policy)

- 1 8. That our AMA encourage CMS to both: a) base disproportionate share hospital payments and
2 uncompensated care payments to hospitals on actual uncompensated care data; and b) study the
3 costs to independent physician practices of providing uncompensated care. (New HOD Policy)
4
- 5 9. That our AMA collect data and conduct research both: a) to document the role that physicians
6 have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of
7 the Medicare budget allocated to physician services that more accurately reflects practice costs
8 and changes in health care delivery. (Directive to Take Action)

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

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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.

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²⁶ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2018. Medicare program; Revisions to payment policies under the physician fee schedule and other revisions to Part B for CY 2019; Medicare shared savings program requirements; Quality payment program; and Medicaid promoting interoperability program. Proposed rule. *Federal Register*. July 27, 2018.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801
(I-18)

Introduced by: Medical Student Section

Subject: Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

Whereas, Under Section 1115 of the Social Security Act, the Secretary of Health and Human Services may approve state waivers for demonstration projects that are experimental in nature;¹ and

Whereas, Section 1115 demonstrations allow states to use federal Medicaid funds for costs that would not otherwise be covered, amounting to approximately one-third (over \$100 billion) of Medicaid spending in 2015;^{1,2} and

Whereas, States have used these waivers to expand coverage, change delivery systems, alter benefits and cost sharing, modify provider payments, and extend coverage in emergency situations;³ and

Whereas, Final evaluations of demonstrations have historically been required by the Centers for Medicare & Medicaid Services (CMS) only after the final expiration of the demonstration, rather than at the end of each three-to five-year demonstration cycle;³ and

Whereas, Demonstrations may be renewed for multiple three-to five-year demonstration cycles, resulting in demonstrations running for decades without proper analyses and data reporting;³ and

Whereas, An interim report submitted by the state of Massachusetts to CMS in 2016 regarding a demonstration initially approved in 1997 lacked data measuring the effectiveness of nearly \$700 million used to create and fund new hospital Medicaid payment delivery systems;³ and

Whereas, Massachusetts currently spends approximately 40% of its state budget on Medicaid services, and CMS has previously encouraged the state to move to more aggressive accountability measures;^{4,5} and

Whereas, Recent interim evaluations of demonstrations in Arkansas and Arizona lacked important information necessary for proper assessment of those demonstrations as well;³ and

¹ Demonstration Projects. *Social Security Administration Compilation of the Social Security Laws*. 2014; https://www.ssa.gov/OP_Home/ssact/title11/1115.htm#ftn27. Accessed March 17, 2018.

² MEDICAID DEMONSTRATIONS: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures. *U.S. Government Accountability Office*. 2018; GAO-18-220.

³ Angelette, Stephen and Evans, Jennifer. 1115 Waivers and the Future of Medicaid. *American Bar Association*. 2015; 11(5). https://www.americanbar.org/publications/aba_health_esource/2014-2015/january/1115.html Accessed March 30, 2018.

⁴ Testimony: Joint Hearing of the House & Senate Committees on Ways & Means and the Joint Committee on Health Care Financing. *The Commonwealth of Massachusetts*. 2017:1.

⁵ Sanchez, Jeffrey. Tackling Medicaid in Massachusetts. *Health Affairs Blog*. 2015; <https://www.healthaffairs.org/doi/10.1377/hblog20150622.048691/full/> Accessed April 4, 2018.

Whereas, In ten states, including Arizona, over 75% of the Federal Medicaid Expenditures go towards Section 1115 demonstrations;³ and

Whereas, The U.S Government Accountability Office (GAO) published a study in January 2018 showing that state-led evaluations of demonstrations had limited usefulness for federal decision-making due to the temporal gaps in comprehensive results, and CMS officials acknowledge this fact;³ and

Whereas, The GAO has made the following recommendations to CMS: (1) establish written procedures for requiring final evaluation reports at the end of each demonstration cycle, (2) issue criteria for when it will allow limited evaluations of demonstrations, and (3) establish a policy for publicly releasing findings from federal evaluations of demonstrations;³ and

Whereas, CMS officials have said that the agency plans to require appropriate evaluation at the end of each demonstration cycle, but still lacks any written procedures for implementing these requirements;³ therefore be it

RESOLVED, That our American Medical Association encourage the Centers for Medicare & Medicaid Services to establish written procedures that require final evaluation reports of Section 1115 Demonstrations at the end of each demonstration cycle, regardless of renewal status.
(New HOD Policy)

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

Date Received: 9/21/18

RELEVANT AMA POLICY:

Medicaid Waivers for Managed Care Demonstration Projects H-290.987

(1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package.

Citation: (BOT Rep. 24, A-95; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04; Modified: CMS Rep. 1, A-14)

Opposition to Medicaid Work Requirements H-290.961

Our AMA opposes work requirements as a criterion for Medicaid eligibility.

Citation: Res. 802, I-17; Reaffirmation: A-18

Medicaid Expansion Options and Alternatives H-290.966

1. Our AMA encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap.
2. Our AMA encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low income adult populations.
3. Our AMA encourages the Centers for Medicare & Medicaid Services to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults.
4. Our AMA advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid web site.

Citation: CMS Rep. 5, I-14; Reaffirmed: CMS Rep. 02, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802
(I-18)

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

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

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

Whereas, Recent presentations by CMS Secretary Verma have stressed moving Medicare Shared Savings ACO's to reduce the number of upside only Medicare Shared Savings ACO's (MSSP ACO's) by moving them to a two-track model and reducing the length of time that existing MSSP ACO's can remain in the program to two years and lowering their share of savings to 25%. Telemedicine initiatives were offered as a way to offset the risks. The rationale is that new risk based ACO's will be able to move to Value Based Care as outlined in MACRA. The risk based ACO's will have to remain in the program for 5 years starting in 2020; and

Whereas, Given that 15 of the 18 Next Gen (risk based ACO's) have prior MSSP experience and are huge organizations with prior experience with integration and cost reductions, the fact that they only saved 1.7% is alarming. Eliminating the MSSP prevents new organizations from acquiring the experience in a lower risk environment. (Infrastructure costs, etc. for an ACO). It reinforces the fact that smaller organizations and private practitioners will have no access to APM's and the bonuses related to Value Based Care; and

Whereas, Recent results from CMS MSSP ACO's viewed on the whole do not show consistent "significant savings" for many organizations, and many others show no savings. Thus, making the losses associated with the move to involve "downside risk" even more likely and the pathway more treacherous. (CMS Report 2017).³ This will limit the number of risk-based organizations to only very large previously integrated and well capitalized healthcare systems; and

Whereas, Recent publications (NEJM 9/5/18), four which have done subgroup analyses of the results, have shown a differential in savings when MSSP ACO's owned by physicians are reviewed versus hospital integrated systems. The physician owned systems have substantially greater savings; and

Whereas, Risk based ACO's require prior ACO experience, organizational infrastructure, linked health information technology (HIT), and business resources. Large amounts of capital are necessary to form and run a given system. The necessary funds are only available to large well capitalized health care systems. These requirements create a vulnerability which will lead to further consolidation of medical practices given the need for capital needed to allow them to participate in Advance Payment Models (APM's). Thus, it will also expose integrated healthcare systems to takeovers by financial firms or other larger systems; and

Whereas, consolidation of physicians' practices has not led to greater savings. Further consolidation forced by eliminating the MSSP ACO program may cause some systems to drop out of the MSSP program. This will likely further raise costs while making it impossible for smaller groups of physicians and rural physicians to participate in ACO's. The opportunity to participate in value-based care (APM's) to receive bonuses in MACRA will not be accessible. Elimination and/or modification of MIPS makes the opportunity for bonuses based on superior physician performance impossible; therefore be it

RESOLVED, That our American Medical Association advocate for the continuation of up side only risk Medicare Shared Savings ACO (MSSP ACO) program as an option from the Centers for Medicare and Medicaid Services, particularly for physician owned groups (New HOD Policy); and be it further

RESOLVED, That our AMA develop educational resources and business analytics to help physicians complete due diligence in evaluating the performance of hospital integrated systems before considering consolidation. Specific attention should be given to the evaluation of transparency on past savings results, system finances, quality metrics, physician workforce stability and physician job satisfaction, and the cost of clinical documentation software (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate the characteristics of successful physician owned MSSP ACOs and participation in alternative payment models (APMs) to create a framework of the resources and organizational tools needed to allow smaller practices to form virtual ACOs that would facilitate participation in MSSP ACOs and APMs. (Directive to Take Action)

Fiscal Note: Estimated cost of \$30,000 to implement resolution.

Received: 09/25/18

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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 cancerⁱ; 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)ⁱ; and

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

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

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

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

Whereas, Insurance companies are not required to pay for additional screeningⁱⁱⁱ; 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)

ⁱ Berg WA. Supplemental Breast Cancer Screening in Women with Dense Breasts Should be Offered with Simultaneous Collection of Outcomes Data. *Annals of internal medicine*. 2016;164(4):299-300. doi:10.7326/M15- 2977.

ⁱⁱ Breast Density Notification Laws by State — Interactive Map. Available at <http://www.diagnosticsimaging.com/breast-imaging/breast-density-notification-laws-state--interactive-map>.

ⁱⁱⁱ Dense Breast Info. Available at <http://densebreast-info.org/legislation.aspx>.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 804
(I-18)

Introduced by: Alaska

Subject: Arbitrary Documentation Requirements for Outpatient Services

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

1 Whereas, Onerous administrative requirements can reduce practice efficiency and contribute to
2 physician burnout, without improving patient care; and
3

4 Whereas, Fee for service payers including Medicare and Medicaid have historically advised that
5 clinical documentation for outpatient services should be completed in a “timely manner” (or
6 within some other non-specific timeframe); and
7

8 Whereas, A new Alaska Medicaid regulation arbitrarily imposes a “72 hour” rule, prohibiting
9 payment for any outpatient claim unless documentation for the provided service had been
10 substantively completed within three days of the visit (including weekends/holidays); and
11

12 Whereas, Neither government nor private health insurers should unilaterally impose
13 burdensome documentation requirements without at least some evidence that the new rules will
14 improve patient outcomes; and
15

16 Whereas, Alaska’s new regulation also includes a provision that the three day requirement shall
17 be waived if a provider’s professional body has adopted policy specifying that a longer time
18 period for documentation is appropriate; therefore be it
19

20 RESOLVED, That our American Medical Association agree that documentation for outpatient
21 physician services should be completed in a timely manner (New HOD Policy); and be it further
22

23 RESOLVED, That for circumstances in which more specific definitions of timeliness are
24 required, AMA policy is that documentation for outpatient services should be completed, when
25 possible, within 14 days of a provided service (New HOD Policy); and be it further
26

27 RESOLVED, That our AMA work with government health plans and private insurers to help
28 them better understand the unintended consequences of imposing documentation rules with
29 unrealistically short timeframes, and that our AMA oppose the use of such rules or regulations in
30 determining whether submitted claims are valid and payable. (Directive to Take Action)

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

Received: 09/28/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805
(I-18)

Introduced by: Florida

Subject: Prompt Pay

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

Whereas, Current AMA policy declares that it is a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days (H-190.959); and

Whereas, The AMA is still working to ensure that the 14-day prompt payment objective is achieved; and

Whereas, Advances in automation and technology enable insurance companies and managed care plans to pay clean claims on the day received; therefore be it

RESOLVED, That American Medical Association policy H-190.959 be amended by addition and deletion to read as follows:

Physician Reimbursement by Health Insurance and Managed Care Companies

1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within ~~fourteen~~ three days.

2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within ~~five~~ one business days to allow prompt resubmission of a clean claim.

3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment. (Modify Current HOD Policy)

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

Received: 09/27/18

RELEVANT AMA POLICY

Physician Reimbursement by Health Insurance and Managed Care Companies H-190.959

1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days.
2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim.
3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment.

Citation: (Sub. Res. 713, A-02; Modified: Res. 714, A-03; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: Res 132, A-14; Reaffirmed: Sub. Res. 715, A-15)

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

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-I-18

Subject: Information Regarding Animal-Derived Medications (Resolution 515-A-18)

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

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 INTRODUCTION

2
3 Resolution 515-A-18, "Information Regarding Animal Derived Medications," introduced by the
4 Michigan Delegation and referred by the House of Delegates (HOD) asked:

5
6 That our American Medical Association (AMA): (1) Support efforts to improve cultural
7 awareness pertaining to the use of animal-derived medications when considering different
8 prescription options. (2) Encourage the U.S. Food and Drug Administration to make available
9 to the public an easily accessible database that identifies medications containing ingredients
10 derived from animals.

11
12 Some chemical products used as inactive excipients for prescription drugs, as well as some active
13 prescription medications and also some surgical implants, dressings, and mesh, are derived from
14 animal sources. The consumption or use of such products may be objectionable to certain religions
15 or based on consumer choice. The objective of this report is to summarize the issue and current
16 evidence related to animal-derived components of medical products.

17 BACKGROUND

18
19
20 Some religious faiths forbid the consumption or use of certain animals and substances derived from
21 them. Additionally, individuals who adhere to a vegetarian or vegan diet may prefer to avoid
22 animal-derived medical products. Individuals who want to avoid animal-derived substances for
23 religious or cultural reasons may inquire about the origin or source of the ingredients in their
24 medical products for informed decision-making regarding treatment with the product. Frequently,
25 however, the information regarding ingredients or composition in medications is difficult to obtain
26 by physicians, pharmacists, and patients.¹

27
28 Many pharmaceutical products (both active and inactive ingredients used in capsules, tablets,
29 injections, vaccines, creams) and surgical products (implants, wound dressings, surgical mesh)
30 contain ingredients derived from animal sources. Animal-derived ingredients (ADIs) are used in
31 many medical fields and cover an array of products usually at minimal concentrations.¹ However, a
32 substantial percentage of patients and physicians are unaware that some medications and medical
33 products contain animal products;² one survey indicated that 84% of patients and 70% of
34 physicians were unaware that several medications contain ADIs. Additionally, 70% of physicians
35 thought it was important to inform patients who might object if such medications are prescribed.³
36 Some authors have even suggested obtaining informed consent before using animal-derived
37 products.¹

POLICY AND LAW

The U.S. Pharmacopeial Convention is a private, nongovernmental organization that publishes the United States Pharmacopeia (USP) and the National Formulary (NF) as official compendia, collectively called the USP-NF. The Federal Food, Drug and Cosmetic Act (FFDCA) expressly recognizes the USP quality standards for medicines.⁴ Although much of the USP-NF is legally enforceable, the USP chapters numbered above <999> are general information and generally do not contain any mandatory requirements, but can include recommendations that may help a firm meet the requirements of current good manufacturing processes (CGMPs) as defined by the U.S. Food and Drug Administration (FDA).⁵

FDA Guidance regarding CGMP includes recommendations and precautions when manufacturing ADIs to ensure that contamination by pathogenic agents does not occur. No guidance regarding labeling of ADIs could be located. Although the FDA does have a database that provides information on inactive ingredients present in FDA-approved drug products, its main purpose is to aid industry in drug development; once an inactive ingredient is part of the formulation for an approved drug product, it is no longer considered new and may require less extensive review when used again. The database includes no information regarding the source of the ingredient.⁶

USP-NF general chapter <7> “Labeling” details the requirements for the labeling of active ingredients in pharmaceutical products. No discussion of ingredient source is included. It is noted, however, that many monographs have unique labeling requirements that should be used consistently. USP-NF informational chapter <1091> “Labeling of Inactive Ingredients” states that all ingredients should be disclosed for all medications. The information can be found on the package or insert of a prescription drug and on the drug facts label on the outside of the box for over-the-counter drugs. No requirement exists for a manufacturer to declare how an ingredient is sourced. Additionally, the Code of Federal Regulations calls for all ingredients to be listed, but inactive ingredients are exempt from provisions on misbranding, including some that relate to false or misleading labeling.⁷

CULTURAL CONSIDERATIONS

Some religious groups avoid products from certain animals and many patients have strong religious convictions and beliefs. Vegetarians do not consume foods either directly obtained or using products from the slaughter of an animal. Vegans do not consume any foods originating from animals.

Several investigators have surveyed worldwide religious leaders for their opinions regarding the acceptability of certain medical products, both medications and surgical implants/dressings/mesh, for their religions.^{1,8-11} The surveys generally focused on the six largest religions worldwide and reported varied practices. Many Hindus and Sikhs do not approve of the use of bovine- or porcine-derived products and also follow vegetarian diets. Many who practice Islam or Judaism do not accept the use of porcine-derived products. No principle in Buddhism prohibits the use of animal-derived medical products; however, many members of one of the two major branches follow a vegetarian diet. Most Christians, other than those who follow vegetarian or vegan diets, do not have restrictions. Although Jehovah’s Witnesses refuse blood transfusions, all other medical related products and decisions are at the discretion of the patient and physician. Notably, leaders from all surveyed religions stated that the use of animal-derived medical products would be accepted in the absence of any other alternative or in emergency situations. In difficult situations, religious leaders can also be contacted for guidance.

OTHER CONSIDERATIONS

Various communication practices for patient-directed medication information including readability, container labeling (font, format, and organization), information content length, and supplementary medication instructions have been described, but do not address ingredient lists and source.¹²

Reports of medication non-adherence or discontinuation because of ADI avoidance exist.¹³ Some authors have suggested that when healthcare professionals listen to patients' cultural beliefs, actively involve them in medication prescribing decisions, and take their views and preferences into account, adherence is more likely.¹⁴

Nevertheless, ADI information is inconsistently reported, difficult to obtain, and sometimes incorrect.^{2,15} Also noteworthy is the fact that excipients and inactive ingredients likely differ between branded and generic forms of medications; therefore, knowledge of the ingredients in a particular branded medication will not guarantee knowledge of generic versions. Some drugs, especially those produced in gelatin capsules, may be available in alternative formulations that do not contain ADIs. Literature discussing clinical decision support systems for physicians and drug databases used by pharmacists has not addressed the issue of ADIs and the inclusion of relevant ADI information. If the source of ADIs, or the fact that an ingredient is an ADI, were required labeling for manufacturers, the potential would exist for this information to be included in the datasets used by clinical decision support systems and drug databases downstream.

PROBLEM MEDICAL PRODUCTS

Both active and inactive pharmaceutical ingredients as well as implants, dressings, and mesh used in surgery can contain ADIs. Some of the more common examples of these ADIs are included in discussion below.

Active Ingredients

The following are examples of products that contain an active ingredient derived from an animal source:

- Conjugated estrogens (Premarin) are derived from the urine of pregnant mares.¹⁶
- Low molecular weight heparin is porcine-derived.¹⁷
- Corticotropin is obtained from porcine pituitary gland.¹⁸
- Hyaluronidase is derived from crude extracts of ovine or bovine testicular tissue.¹⁹
- Pancreatin (also known as pancreatic enzymes, pancrelipase) is bovine derived.²⁰

The product information for these medications indicates that they are animal-derived. However, for some, the information is difficult to locate, often only becoming obvious because of a statement in the "allergy" or "contraindications" section (e.g., This medication is contraindicated in patients with sensitivity to proteins of porcine origin.).

Inactive Ingredients

In a recent review, the use of ADIs in the 100 most commonly prescribed medications in primary care in the United Kingdom found that 74 contained at least one of the three most common excipient ADIs used – gelatin, lactose, and magnesium stearate.¹⁵ Of these 74 products, 42 provided no indication of the presence of an ADI, and 2 products incorrectly stated that no animal content was contained in the product.¹⁵

1 Gelatin is a generic term for a mixture of purified protein fractions obtained by hydrolysis of
2 animal collagen obtained from bovine or porcine bone, or from bovine, porcine, or fish skin. It is
3 most frequently used in the capsules of medications. Due to the demand for gelatin-free
4 medication, the production of vegetarian capsules made from hypromellose has expanded, and the
5 use of bioreactors utilizing “cellular agriculture” to create purified proteins that are assembled into
6 collagen and then made into gelatin is becoming popular; but animal-derived gelatin is still used
7 commonly.^{2,21}

9 Lactose is a natural disaccharide present in the milk of most mammals and is traditionally extracted
10 from milk using bovine rennet. Some manufacturers now use a vegetarian process instead of
11 bovine rennet to extract lactose from bovine milk, but this has caused confusion about suitability
12 for those who avoid bovine products.¹⁵ Lactose is widely used as a filler and diluent in tablets and
13 capsules and is also used as a diluent in dry-powder inhalations, in the preparation of sugar-coating
14 solutions, and in some injections.^{2,15}

16 Stearic acid, utilized as magnesium stearate in products, is a fatty acid sourced from rendered
17 bovine, porcine, or ovine fat or produced from vegetable matter. It is primarily used as a lubricant
18 in capsule and tablet manufacture and improves the solubility of some medications. If the source of
19 the magnesium stearate is not indicated on a drug label, whether or not it is an ADI is unknown and
20 difficult to determine.²

22 *Vaccines*

24 Materials used in the production of some vaccines, e.g., excipients or nutritional supplements for
25 cell cultures, are ADIs. These include gelatin, trypsin (usually bovine sourced), and bovine serum
26 or albumin.²² Religious scholars distinguish between the use of ADIs in oral or non-oral
27 medications and have issued rulings or waivers that allow use of non-oral medications containing
28 ADIs, such as vaccines.² Despite this distinction, reports persist of concern with ADIs in
29 vaccines.¹⁵

31 *Surgical Sutures, Implants, Dressings, and Mesh*

33 The use of synthetic and biological products is widespread in surgeries, and the use of a biologic
34 product that is prohibited or is sacred in a surgical setting is a concern.^{8,10} Sutures used to close
35 wounds or surgical incisions can contain animal-derived ingredients. A recent study confirmed the
36 frequent use of ADIs, such as collagen membrane, collagen gel, fibrin glue, fibrinogen, aprotinin
37 and some types of chitosan culture media and scaffold, in various arthroscopy products.¹⁰ Allograft
38 and xenograft mesh products have also been cited as problematic for patients with issues related to
39 the use of ADIs.¹¹ Authors encourage surgeons to know the source of the products they use as well
40 as the basic requirements of their patient’s faith, possibly even gaining informed consent before the
41 use of animal-derived surgical implants.^{8,11}

43 CURRENT AMA POLICY

45 No AMA policy addresses this issue.

47 CONCLUSION

49 Several medication ingredients, both active and inactive, and surgical products contain ingredients
50 derived from animal sources. Patients may have strong religious convictions and cultural beliefs
51 leading them to object to using medical products with animal-derived ingredients.

1 It has been documented that physicians may have a hard time determining the origin of ingredients
2 because the information is inconsistently reported, difficult to obtain, and sometimes incorrect.
3 Many times, reading the list of ingredients of a medical product will not clarify if the product
4 contains any animal-derived ingredients or components. Additionally, the products can vary in
5 regard to ADIs based on the manufacturer, and between brand name and generic versions.
6

7 Because no requirement exists for a manufacturer to declare how an ingredient is sourced on label
8 information, this information is not present in clinical decision support systems for physicians and
9 drug databases. Including additional information, such as the presence of ADIs and their source, in
10 the ingredients lists on drug labels and in product information would be beneficial because this
11 information could then be included in information systems used by clinicians and would be more
12 accessible to patients.
13

14 RECOMMENDATION

15
16 The Board of Trustees recommends the following be adopted in lieu of Resolution 515-A-18, and
17 the remainder of the report be filed:
18

19 Animal-Derived Ingredients

20 Our AMA:

- 21
22
23 1. Urges the U.S. Food and Drug Administration to require manufacturers to include all
24 ingredients and components present in medical products on the product label, including
25 both active and inactive ingredients, and denote any derived from an animal source. (New
26 HOD Policy)
27
- 28 2. Encourages cultural awareness regarding patient preferences associated with medical
29 products containing active or inactive ingredients or components derived from animal
30 sources. (New HOD Policy)

Fiscal Note: Less than \$500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 901
(I-18)

Introduced by: Medical Student Section

Subject: Support for Preregistration in Biomedical Research

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, Current AMA policy calls for physicians to “report the results of research accurately, including subsequent negative findings”, particularly when “the findings do not support the research hypothesis”;¹ and

Whereas, There are hurdles to the publication of negative research findings because of publication bias wherein journals are less likely to accept manuscripts reporting negative findings;² and

Whereas, The AMA supports the reproducibility of research findings by advocating that scientific research “employ study designs that will yield scientifically valid and significant data”;³ and

Whereas, There is a systemic lack of reproducibility among published biomedical research studies⁴, as highlighted by a recent report finding that nearly 70% of researchers were unable to reproduce another scientist’s results;^{4,5} and

Whereas, Preregistration of a research study is the act of committing to clearly defined research questions and analytical plans prior to the observation of the research outcomes, usually achieved by posting an analysis plan to an independent registry;⁶ and

Whereas, Establishing hypotheses prior to observation of outcomes has been associated with a four-fold reduction in rates of reporting false positive findings, suggesting that preregistration can increase replicability of research;⁷ and

Whereas, The proportion of large clinical trials reporting negative findings increased from 43% to 92% after preregistration of clinical trials became mandatory in the United States, showing that “preregistration is correlated with outcomes that suggest reduced publication or reporting biases;”⁸ therefore be it

¹ AMA Code of Medical Ethics Opinion E-7.2.1 Principles for Disseminating Research Results

² Nosek BA, Ebersole CR, DeHaven AC, Mellor DT. The Preregistration Revolution. *Proceedings of the National Academy of Sciences*. 2018;115(11):2600-2606. doi:[10.1073/pnas.1708274114](https://doi.org/10.1073/pnas.1708274114); Franco A, Malhotra N, Simonovits G. Publication Bias in the Social Sciences: Unlocking the File Drawer. *Science*. 2014;345(6203):1502-1505.

³ AMA Code of Medical Ethics Opinion E-7.1.3 Study Design and Sampling

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⁵ Baker M. 1,500 Scientists Lift the Lid on Reproducibility. *Nature*. 2016;533(7604):452-454.

⁶ Nosek BA, et al. The Preregistration Revolution.

⁷ Swaen GGMH, Teggeler O, van Amelsvoort LGPM. False Positive Outcomes and Design Characteristics in Occupational Cancer Epidemiological Studies. *International Journal of Epidemiology*. 2001;30(5):948-954.

⁸ Kaplan RM, Irvin VL. Likelihood of Null Effects of Large NHLBI Cancer Trials Has Increased Over Time. *PLoS One*. 2015;10(8):e0132382; Nosek BA, et al. The Preregistration Revolution.

- 1 RESOLVED, That our American Medical Association support preregistration in order to mitigate
2 publication bias and improve the reproducibility of biomedical research. (New HOD Policy)

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

Date Received: 09/21/18

RELEVANT AMA POLICY

E-7.1.3 Study Design & Sampling

To be ethically justifiable, biomedical and health research that involves human subjects must uphold fundamental principles of respect for persons, beneficence, and justice. These principles apply not only to the conduct of research, but equally to the selection of research topics and study design.

Well-designed, ethically sound research aligns with the goals of medicine, addresses questions relevant to the population among whom the study will be carried out, balances the potential for benefit against the potential for harm, employs study designs that will yield scientifically valid and significant data, and generates useful knowledge. For example, research to develop biological or chemical weapons is antithetical to the goals of the medical profession, whereas research to develop defenses against such weapons can be ethically justifiable.

Physicians who engage in biomedical or health research with human participants thus have an ethical obligation to ensure that any study with which they are involved:

- (a) Is consistent with the goals and fundamental values of the medical profession.
- (b) Addresses research question(s) that will contribute meaningfully to medical knowledge and practice.
- (c) Is scientifically well designed to yield valid data to answer the research question(s), including using appropriate population and sampling controls, clear and appropriate inclusion/exclusion criteria, a statistically sound plan for data collection and analysis, appropriate controls, and when applicable, criteria for discontinuing the study (stopping rules).
- (d) Minimizes risks to participants, including risks associated with recruitment and data collection activities, without compromising scientific integrity.
- (e) Provides mechanisms to safeguard confidentiality.
- (f) Does not disproportionately recruit participants from historically disadvantaged populations or populations whose ability to provide fully voluntary consent is compromised. Participants who otherwise meet inclusion/exclusion criteria should be recruited without regard to race, ethnicity, gender, or economic status.
- (g) Recruits participants who lack the capacity to give informed consent only when the study stands to benefit that class of participants and participants with capacity would not yield valid results. In this event, assent should be sought from the participant and consent should be obtained from the prospective participants legally authorized representative, in keeping with ethics guidance.
- (h) Has been reviewed and approved by appropriate oversight bodies.

[AMA Principles of Medical Ethics: I,II,III,V,VII](#)

Issued: 2016

E-7.2.1 Principles for Disseminating Research Results

Physicians have an ethical responsibility to learn from and contribute to the total store of scientific knowledge. When they engage in biomedical or health research, physicians have obligations as scientists, which include disseminating research findings. Prompt presentation to scientific peers and publication of research findings are foundational to good medical care and promote enhanced patient care, early evaluation of clinical innovations, and rapid dissemination of improved techniques. To fulfill their ethical responsibilities with respect to sharing research findings for the ultimate benefit of patients, physicians should:

- (a) Advocate for timely and transparent dissemination of research data and findings. Physicians should not intentionally withhold information for reasons of personal gain.
- (b) Report the results of research accurately, including subsequent negative findings. This is particularly important where the findings do not support the research hypothesis.
- (c) Maintain a commitment to peer review.
- (d) Disclose sponsorship and conflicts of interest relating to the research, in keeping with ethics guidance.
- (e) Be responsible in their release of research results to the media, ensuring that any information the researcher provides is prompt and accurate and that informed consent to the release of information has

been obtained from research participants (or participants legally authorized representative when the participant lacks decision-making capacity) prior to releasing any identifiable information. In rare circumstances, the potential for misuse of research results could affect the decision about when and whether to disseminate research findings. Physician-researchers should assess foreseeable ramifications of their research in an effort to balance the promise of benefit against potential harms from corrupt application. Only under rare circumstances should findings be withheld, and then only to the extent required to reasonably protect against misuse.

[AMA Principles of Medical Ethics: I,II,III,V,VII](#)

Issued: 2016

Food Additives H-150.998

Our AMA supports the passage of legislation that would amend the Food Additive Act to require evidence based upon scientifically reproducible studies of the association of food additives with an increased incidence of cancer in animals or humans at dosage levels related to the amounts calculated as normal daily consumption for humans before removal of an additive from the market.

Citation: (Sub. Res. 4, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00;

Modified: BOT Rep. 6, A-10)

Increasing Minority Participation in Clinical Research H-460.911

1. Our AMA advocates that:

- a. The Food and Drug Administration (FDA) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
- b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and
- c. Resources be provided to community level agencies that work with those minorities who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities in clinical trials:

- a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs;
- b. Increased outreach to female physicians to encourage recruitment of female patients in clinical trials;
- c. Continued minority physician education on clinical trials, subject recruitment, subject safety, and possible expense reimbursements;
- d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and
- e. Fiscal support for minority recruitment efforts and increasing trial accessibility through transportation, child care, reimbursements, and location.

3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.

BOT Rep. 4, A-08 Reaffirmed: CSAPH Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 902
(I-18)

Introduced by: Medical Student Section

Subject: Increasing Patient Access to Sexual Assault Nurse Examiners

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, One in 6 women and 1 in 33 men have experienced an attempted or completed rape in their lifetime, and there were 323,450 reports of rape or sexual assault in the United States in 2016;^{1,2} and

Whereas, Hospital emergency departments (EDs) typically serve as the primary point of care for survivors of sexual assault, accounting for approximately 65,000–90,000 emergency department visits per year;³ and

Whereas, The medical forensic examination (MFE) consists of a full head-to-toe physical examination focused on documenting a patient's physical injuries and procuring DNA evidence to assist in the prosecution of a case;⁴ and

Whereas, Performing a MFE has been shown to increase prosecution rates, and patients who have chosen to undergo the MFE may do so to gain closure and emotional healing from the traumatic event;⁵ and

Whereas, While the MFE can be completed by a variety of healthcare providers including emergency medicine (EM) physicians, nurses/nurse practitioners, and physician assistants, EM physicians are the primary examiner performing these exams despite recommendations that encourage the involvement of other providers;^{4,6} and

Whereas, The MFE takes on average two hours to perform, must be completed within 72 hours of the assault, and a chain of custody must be maintained where the examiner cannot leave the evidence unattended until it is sealed for storage or handed to an authorized law enforcement agent;^{4,7} and

Whereas, EM physicians typically see 2.48 patients per hour, which makes it difficult to effectively complete the MFE and maintain custody of the evidence alongside their clinical responsibilities;^{4,8} and

¹ RAINN, "Victims of Sexual Violence: Statistics | RAINN," 2018, <https://www.rainn.org/statistics/victims-sexual-violence>.

² Rachel Morgan and Grace Kena, "Criminal Victimization, 2016," 2017, <https://www.bjs.gov/content/pub/pdf/cv16.pdf>.

³ Ashlesha Patel et al., "Assessing the Extent of Provision of Comprehensive Medical Care Management for Female Sexual Assault Patients in US Hospital Emergency Departments," *International Journal of Gynecology & Obstetrics* 123, no. 1 (October 2013): 24–28, <https://doi.org/10.1016/j.ijgo.2013.04.014>.

⁴ Kristin Littel, "A National Protocol for Sexual Assault Medical Forensic Examinations - Adults/Adolescents Second Edition," 2013, <https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf>.

⁵ Janice Du Mont, Deborah White, and Margaret J. McGregor, "Investigating the Medical Forensic Examination from the Perspectives of Sexually Assaulted Women," *Social Science & Medicine* 68, no. 4 (February 1, 2009): 774–80, <https://doi.org/10.1016/J.SOCSCIMED.2008.11.010>.

⁶ Margaret K Sande et al., "Sexual Assault Training in Emergency Medicine Residencies: A Survey of Program Directors," *The Western Journal of Emergency Medicine* 14, no. 5 (September 2013): 461–66, <https://doi.org/10.5811/westjem.2013.2.12201>.

⁷ "What Is a Rape Kit? | RAINN," accessed April 11, 2018, <https://www.rainn.org/articles/rape-kit>.

⁸ Joseph Harrington, "Patient-Per-Hour Staffing Ratios Over the Last 5 Years of EDBA Surveys," ACEP Now, 2016, http://www.acepnow.com/article/emergency-department-benchmarking-alliance-releases-2014-data-on-staffing-physician-productivity/acep_0116_pg13b/.

Whereas, There is currently no national consensus on EM resident education for sexual assault examinations, leading to EM physicians who are undertrained to complete the MFE;⁹ and

Whereas, Sexual assault nurse examiners (SANE) are health care personnel specially trained to perform the MFE and their involvement is associated with higher rates of survivors' psychological recovery and offender prosecution due to better collection of forensic data;^{10,11} and

Whereas, Although there are now over 600 SANE programs nationwide, many EDs lack access to SANE personnel, especially in rural or smaller communities;^{12,13} and

Whereas, The United States Government Accountability Office released a study highlighting "weak stakeholder support for examiners" as one of the main reasons for poor availability of SANE personnel;¹⁴ and

Whereas, The American College of Emergency Physicians, the International Association of Forensic Nurses, and the Department of Justice all recommend that the MFE be performed by specially trained medical personnel such as a SANE, and the Police Foundation in Texas found that there is "reluctance by nurses, hospital administrators and criminal justice officials to [have] non-SANEs conduct medical forensic exams";^{14,15} and

Whereas, Expanding the SANE program nationwide may decrease the burden on ED physicians and provide better care to sexual assault survivors;^{4,15} therefore be it

RESOLVED, That our American Medical Association advocate for increased patient access to sexual assault nurse examiners in the emergency department. (New HOD Policy)

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

Date Received: 09/21/18

RELEVANT AMA POLICY

Sexual Assault Survivors H-80.999

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (A) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (B) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (C) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (D) be informed of these rights and the policies governing the sexual assault evidence kit; and (E) access to emergency contraception information and treatment for pregnancy prevention.

⁹ Margaret K Sande et al., "Sexual Assault Training in Emergency Medicine Residencies: A Survey of Program Directors.," *The Western Journal of Emergency Medicine* 14, no. 5 (September 2013): 461–66, <https://doi.org/10.5811/westjem.2013.2.12201>.

¹⁰ Megan R. Greeson and Rebecca Campbell, "Coordinated Community Efforts to Respond to Sexual Assault," *Journal of Interpersonal Violence* 30, no. 14 (September 13, 2015): 2470–87, <https://doi.org/10.1177/0886260514553119>.

¹¹ Rebecca Campbell, Debra Patterson, and Lauren F. Lichty, "The Effectiveness of Sexual Assault Nurse Examiner (SANE) Programs," *Trauma, Violence, & Abuse* 6, no. 4 (October 29, 2005): 313–29, <https://doi.org/10.1177/1524838005280328>.

¹² "International Association of Forensic Nurses," 2018, accessed March 28, 2018, <http://www.forensicnurses.org/>

¹³ Liv Osby, "SC Has a Shortage of Nurses for Rape Victims," *The State*, 2017, <http://www.thestate.com/news/local/article162841233.html>.

¹⁴ Katherine M. Iritani, "Information on Training, Funding, and the Availability of Forensic Examiners," *United States Government Accountability Office* 16, no. 334 (2016), <https://www.gao.gov/assets/680/675879.pdf>.

¹⁵ Robert C Davis et al., "IMPACT OF SB1191 ON ACCESSIBILITY OF SEXUAL ASSAULT FORENSIC EXAMS IN TEXAS," 2017, http://www.policefoundation.org/wp-content/uploads/2017/02/PF_Impact-of-SB1191-on-Accessibility-of-Sexual-Assault-Forensic-Exams-in-Texas_2.7.17.pdf.

3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.

Citation: Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: Res. 202, I-17

Sexual Assault Survivor Services H-80.998

Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.

Citation: Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17

Access to Emergency Contraception H-75.985

It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.

Citation: (CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14)

HIV, Sexual Assault, and Violence H-20.900

Our AMA believes that HIV testing should be offered to all victims of sexual assault, that these victims should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained.

Citation: (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 903
(I-18)

Introduced by: Medical Student Section

Subject: Regulating Front-of-Package Labels on Food Products

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, Many front-of-package (FOP) labels on food products feature nutrient claims that suggest or imply that a food has certain nutritional properties related to its content of energy, proteins, fats, carbohydrates, dietary fiber, vitamins, and/or minerals; and

Whereas, FOP labels attract attention, thereby causing consumers to spend less time reading the nutrition facts on the back and side panel of food products^{1,2}; and

Whereas, Research demonstrates that consumers will exhibit a preference for a product with a FOP nutrient claim regardless of its qualitative value³; and

Whereas, Studies show that children perceive food products with nutrient claims on their FOP label as healthier⁴; and

Whereas, Studies of responses to nutrition-related claims in food advertising have found that consumers over-generalize a product's healthfulness based on narrower claims^{5,6,7,8}; and

Whereas, Many front-of-package labels (e.g. "Whole Grain" on sugary cereals and "Good Source of Vitamins and Minerals" on toaster pastries) are placed on products that contain high amounts of added sugar,⁹ meaning they do not comply with the 2015-2020 U.S. Dietary Guidelines' recommendation that food products contain no more than 10% added sugars by calorie value; and

¹ Bix, L., Sundar, R. P., Bello, N. M., Peltier, C., Weatherspoon, L. J., & Becker, M. W. (2015). To See or Not to See: Do Front of Pack Nutrition Labels Affect Attention to Overall Nutrition Information? *Plos One*, 10(10). doi:10.1371/journal.pone.0139732

² Becker, M. W., Sundar, R. P., Bello, N., Alzahabi, R., Weatherspoon, L., & Bix, L. (2016). Assessing attentional prioritization of front-of-pack nutrition labels using change detection. *Applied Ergonomics*, 54, 90-99. doi:10.1016/j.apergo.2015.11.014

³ Hamlin, R. P., McNeill, L. S., & Moore, V. (2014). The impact of front-of-pack nutrition labels on consumer product evaluation and choice: An experimental study. *Public Health Nutrition*, 18(12), 2126-2134. doi:10.1017/s1368980014002997

⁴ Nutrition Claims Influence Health Perceptions and Taste Preferences in Fourth- and Fifth-Grade Children. (2012, September 23). Retrieved April 5, 2018, from <https://www.sciencedirect.com/science/article/pii/S1499404612003958>

⁵ Andrews, J. C., R. G. Netemeyer, and S. Burton. 1998. Consumer generalization of nutrient content claims in advertising. *Journal of Marketing* 62:62-75.

⁶ Kozup, J., E. Creyer, and S. Burton. 2003. Making healthful food choices: The influence of health claims and nutrition information on consumers' evaluations of packaged food products and restaurant menu items. *Journal of Marketing* 67:19-34.

⁷ Gorton, D., C. N. Mhurchu, D. Bramley, and R. Dixon. 2010. Interpretation of two nutrition content claims: A New Zealand survey. *Australian and New Zealand Journal of Public Health* 34:57-62.

⁸ Labiner-Wolfe, J., C. T. J. Lin, and L. Verrill. 2010. Effect of low-carbohydrate claims on consumer perceptions about food products' healthfulness and helpfulness for weight management. *Journal of Nutrition Education and Behavior* 42:315-320.

⁹ Ollberding, N. J., Wolf, R. L., & Contento, I. (2010). Food label use and its relation to dietary intake among US adults. *Journal of the American Dietetic Association*, 110(8), 1233-1237.

Whereas, Evidence shows that individuals who consume diets high in refined carbohydrates are at a greater risk of becoming obese¹⁰, developing diabetes¹¹, and dying from a cardiovascular event¹²; and

Whereas, The Food and Drug Administration (FDA) regulates front-of-package claims by enforcing qualifying criteria that food products must meet for use of each individual nutrient claim¹³; and

Whereas, The FDA has no requirement that food products labeled with nutrient claims that can be generalized to imply healthfulness adhere to specific macronutrient limits; and

Whereas, Studies show that negative cues in the form of warning labels are demonstrated to have a greater impact on consumer food choices than positive health claims^{14,15,16}; and

Whereas, Standardized warning labels have been mandated in Chile on food products high in sugar, salt, fat, and calories since 2016¹⁷; and

Whereas, To avoid having to add warning labels to their products, food companies in Chile have reformulated over 1,500 food products to be lower in sugar, salt, fat, and calories¹⁸; and

Whereas, Chilean consumers purchase more of the foods without warning labels than they did before implementation of the warning labels^{19,20}; and

Whereas, Our AMA and AMA-MSS have established support for consumer-level interventions and education about the effects of excessive dietary sugars (H-150.960, H-150.974, H-150.935, H-150.945, D-150.975, D-150.987); and

Whereas, Our AMA and AMA-MSS have established support for the use of warning labels and plain packaging on sugar-sweetened beverages (H-150.927); therefore be it

¹⁰ Cantoral, A., Téllez-Rojo, M. M., Ettinger, A. S., Hu, H., Hernández-Ávila, M., & Peterson, K. (2015). Early introduction and cumulative consumption of sugar-sweetened beverages during the pre-school period and risk of obesity at 8-14 years of age. *Pediatric Obesity*, 11(1), 68-74. doi:10.1111/ijpo.12023

¹¹ Gross, L. S., Li, L., Ford, E. S., & Liu, S. (2004). Increased consumption of refined carbohydrates and the epidemic of type 2 diabetes in the United States: An ecologic assessment. *The American Journal of Clinical Nutrition*, 79(5), 774-779. doi:10.1093/ajcn/79.5.774

¹² Yang, Q., Zhang, Z., Gregg, E. W., Flanders, W. D., Merritt, R., & Hu, F. B. (2014). Added Sugar Intake and Cardiovascular Diseases Mortality Among US Adults. *JAMA Internal Medicine*, 174(4), 516. doi:10.1001/jamainternmed.2013.13563

¹³ Subpart D—Specific Requirements for Nutrient Content Claims, 58 FR 2413 (1993); 58 FR 17343 (1993), as amended at 58 FR § 44033 (1993); 62 FR § 40598 (1997); 63 FR § 26718 (1998); 63 FR § 40024 (1998); 67 FR § 9585 (2002); 69 FR § 16481 (2004).

¹⁴ Arrúa, A., Machín, L., Curutchet, M. R., Martínez, J., Antúnez, L., Alcaire, F., . . . Ares, G. (2017). Warnings as a directive front-of-pack nutrition labelling scheme: Comparison with the Guideline Daily Amount and traffic-light systems. *Public Health Nutrition*, 20(13), 2308-2317. doi:10.1017/s1368980017000866

¹⁵ Bollard, T., Maubach, N., Walker, N., & Mhurchu, C. N. (2016). Effects of plain packaging, warning labels, and taxes on young people's predicted sugar-sweetened beverage preferences: An experimental study. *International Journal of Behavioral Nutrition and Physical Activity*, 13(1). doi:10.1186/s12966-016-0421-7

¹⁶ Arrúa, A., Curutchet, M. R., Rey, N., Barreto, P., Golovchenko, N., Sellanes, A., . . . Ares, G. (2017). Impact of front-of-pack nutrition information and label design on childrens choice of two snack foods: Comparison of warnings and the traffic-light system. *Appetite*, 116, 139-146. doi:10.1016/j.appet.2017.04.012

¹⁷ Carreño, I. (2015). Chiles Black STOP Sign for Foods High in Fat, Salt or Sugar. *European Journal of Risk Regulation*, 6(04), 622-628. doi:10.1017/s1867299x0000516x

¹⁸ Ares, G., Aschemann-Witzel, J., Curutchet, M. R., Antúnez, L., Machín, L., Vidal, L., & Giménez, A. (2018). Product reformulation in the context of nutritional warning labels: Exploration of consumer preferences towards food concepts in three food categories. *Food Research International*, 107, 669-674. doi:10.1016/j.foodres.2018.03.021

¹⁹ Ares, G., Aschemann-Witzel, J., Curutchet, M. R., Antúnez, L., Machín, L., Vidal, L., & Giménez, A. (2018). Product reformulation in the context of nutritional warning labels: Exploration of consumer preferences towards food concepts in three food categories. *Food Research International*, 107, 669-674. doi:10.1016/j.foodres.2018.03.021

²⁰ Arrúa, A., Curutchet, M. R., Rey, N., Barreto, P., Golovchenko, N., Sellanes, A., . . . Ares, G. (2017). Impact of front-of-pack nutrition information and label design on childrens choice of two snack foods: Comparison of warnings and the traffic-light system. *Appetite*, 116, 139-146. doi:10.1016/j.appet.2017.04.012

- 1 RESOLVED, That our American Medical Association support additional U.S. Food and Drug
- 2 Administration criteria that limit the amount of added sugar a food product can contain if it
- 3 carries any front-of-package label advertising nutritional or health benefits (New HOD Policy);
- 4 and be it further
- 5
- 6 RESOLVED, That our AMA support the use of front-of-package warning labels on foods that
- 7 contain excess added sugar. (New HOD Policy)

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

Date Received: 09/24/18

RELEVANT AMA POLICY

Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-Food and Other Chain Restaurants H-150.945

Our AMA:

1. supports federal, state, and local policies to require fast-food and other chain restaurants with 10 or more units (smaller, neighborhood restaurants could be exempt) to provide consumers with nutrition information on menus and menu boards;
2. recommends that nutrition information in fast-food and other chain restaurants include calorie, fat, saturated fat and trans fat, and sodium labeling on printed menus, and, at a minimum, calories on menu boards, since they have limited space, and that all nutrition information be conspicuous and easily legible;
3. urges federal, state, and local health agencies, health organizations, and physicians and other health professionals to educate people how to use the nutrition information provided in restaurants to make healthier food choices for themselves and their families; and
4. urges restaurants to improve the nutritional quality of their menu offerings--for example, by reducing caloric content; offering smaller portions; offering more fruits, vegetables, and whole-grain items; using less sodium; using cooking fats lower in saturated and trans fats; and using less added sugars/sweeteners.

Citation: (Res. 419, A-07; Reaffirmed in lieu of Res. 413, A-09, Res. 416, A-09 and Res. 418, A-09)

Encouraging Healthy Eating Behaviors in Children Through Corporate Responsibility H-150.935

Our AMA: 1) supports and encourages corporate social responsibility in the use of marketing incentives that promote healthy childhood behaviors, including the consumption of healthy food in accordance with federal guidelines and recommendations; and 2) encourages fast food restaurants to establish competitive pricing between less healthy and more healthy food choices in children's meals.

Citation: (Sub. Res. 402, A-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 435, A-12)

Support for Uniform, Evidence-Based Nutritional Rating System H-150.936

1. Our AMA supports the adoption and implementation of a uniform, nutritional food rating system in the US that meets, at a minimum, the following criteria: is evidence-based; has been developed without conflict of interest or food industry influence and with the primary goal being the advancement of public health; is capable of being comprehensive in scope, and potentially applicable to nearly all foods; allows for relative comparisons of many different foods; demonstrates the potential to positively influence consumers' purchasing habits; provides a rating scale that is simple, highly visible, and easy-to-understand and used by consumers at point of purchase; and is adaptable to aid in overall nutritional decision making.
 2. Our AMA will advocate to the federal government - including responding to the Food and Drug Administration call for comments on use of front-of-package nutrition labeling and on shelf tags in retail stores - and in other national forums for the adoption of a uniform, evidence-based nutrition rating system that meets the above-referenced criteria.
- Citation: (Res. 424, A-10)

Support for Nutrition Label Revision and FDA Review of Added Sugars D-150.974

1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period.
2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added

sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA).

3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.

Citation: (Res. 422, A-14)

Increasing Awareness of Nutrition Information and Ingredient Lists H-150.948

Our AMA supports federal legislation or rules requiring restaurants, retail food establishments, and vending machine operators that have menu items common to multiple locations, as well as all school and workplace cafeterias, especially those located in health care facilities, to have available for public viewing ingredient lists, nutritional information, and standard nutrition labels for all menu items.

Citation: (Sub. Res. 411, A-04; Reaffirmation A-07; Reaffirmed in lieu of Res. 413, A-09, Res. 416, A-09 and Res. 418, A-09; Modified: BOT Rep. 1, A-14)

Strategies to Reduce the Consumption of Beverages with Added Sweeteners H-150.927

Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption, and support evidence-based strategies to reduce the consumption of SSBs, including but not limited to, excise taxes on SSBs, removing options to purchase SSBs in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption, such as controlling portion sizes; limiting options to purchase or access SSBs in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and replacing SSBs with healthier beverage choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage choices for students.

Citation: CSAPH Rep. 03, A-17;

Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake H-150.929

Our AMA will:

(1) Call for a step-wise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade. Food manufacturers and restaurants should review their product lines and reduce sodium levels to the greatest extent possible (without increasing levels of other unhealthy ingredients). Gradual but steady reductions over several years may be the most effective way to minimize sodium levels.

(2) To assist in achieving the Healthy People 2010 goal for sodium consumption, will work with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, and other interested partners to educate consumers about the benefits of long-term, moderate reductions in sodium intake.

(3) Recommend that the FDA consider all options to promote reductions in the sodium content of processed foods.

Citation: CSAPH Rep. 01, A-16

Obesity as a Major Health Concern H-440.902

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of patients with obesity; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat patients affected by obesity.

Citation: Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04; Reaffirmation A-10; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Modified: Res. 402, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 904
(I-18)

Introduced by: Medical Student Section

Subject: Support for Continued 9-1-1 Modernization and the National Implementation of Text-to-911 Service

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, The current 9-1-1 system is primarily built upon an infrastructure that does not uniformly support modern communications technologies including texting, geolocation, and images;^{1, 2} and

Whereas, Current 9-1-1 infrastructure has continuously been shown to be vulnerable to preventable outages and cyberattacks, which have already temporarily left thousands without access to emergency services;^{3, 4, 5} and

Whereas, The Federal Communications Commission (FCC) has already recommended that Congress increase federal incentives to boost state and local 9-1-1 modernization efforts;⁶ and

Whereas, Internet protocol (IP)- based communication technologies allow the transmission of data over the internet, allowing for increased information (such as text and geolocation) to be obtained by the receiver compared to old circuit-switch communication;⁷ and

Whereas, Congress has failed to nationally incorporate IP based technology into existing 9-1-1 infrastructure, which may lead to inaccurate caller location accuracy on calls over wireline in multiple situations;⁸ and

Whereas, 95% of Americans own at least one cellphone, 77% own at least one smartphone, and over 70% of all 9-1-1 calls are made from cellphones and other handheld devices;^{9, 10} and

Whereas, While the IP-based geolocation accuracy of handheld devices averages about 4.9 meters, current U.S. standards merely mandate that 67% of 9-1-1 calls are accurate within range of 50 meters, a standard that has not been updated since 2012;^{11, 12} and

¹ Federal Communications Commission. 2013. Pursuant to the Next Generation 911 Advancement Act of 2012 (Pub. L. No. 112-96 (2012)). Legal and Regulatory Framework for Next Generation 911 Services Report to Congress and Recommendations. Section 1.

² Next Generation 9-1-1 Advancement Act of 2011, 47 U.S.C §158. (2012)

³ Public Safety and Homeland Security Bureau. Federal Communications Commission. 2013. Impact of the June 2012 Derecho on Communications Networks and Services: Report and Recommendations. Sections 1, 7.4, & 8.

⁴ Public Safety and Homeland Security Bureau. Federal Communications Commission. 2014. April 2014 Multistate 911 Outage: Cause and Impact. Sections 1, & 4.2.

⁵ Simpson, D. (2016, February 17). Creating a Culture of Cybersecurity in America's 911 Call Centers. Retrieved March 28, 2018, from <https://www.fcc.gov/news-events/blog/2016/01/28/creating-culture-cybersecurity-america's-911-call-centers>

⁶ Federal Communications Commission. 2013. Pursuant to the Next Generation 911 Advancement Act of 2012 (Pub. L. No. 112-96 (2012)). Legal and Regulatory Framework for Next Generation 911 Services Report to Congress and Recommendations. Section 4.1.1.2

⁷ Federal Communications Commission. 2013. Pursuant to the Next Generation 911 Advancement Act of 2012 (Pub. L. No. 112-96 (2012)). Legal and Regulatory Framework for Next Generation 911 Services Report to Congress and Recommendations. Section 3.1.2.

⁸ Federal Communications Commission. 2017. Inquiry Concerning 911 Access, Routing, and Location in Enterprise Communications Systems: Notice of Inquiry – PS Docket No. 17-239. Sections 1 & 2.

⁹ Mobile Fact Sheet. Pew Research Center. (2018, February 05). Retrieved March 28, 2018, from <http://www.pewinternet.org/fact-sheet/mobile/>

¹⁰ Federal Communications Commission. 2015. Consumer Guide: 911 Wireless Services. Available at <https://transition.fcc.gov/cgb/consumerfacts/wireless911srvc.pdf>

¹¹ 911 service, 47 C.F.R. § 20.18(h) (2012).

¹² GPS Accuracy. (2017, December 5). Retrieved March 25, 2018, from <https://www.gps.gov/systems/gps/performance/accuracy/>

Whereas, Increased 9-1-1 response times, due to factors such as imprecise call tracking, can lead to increased morbidity in cardiac arrest;¹³ and

Whereas, The Americans with Disabilities Act of 1990 mandates that 9-1-1 services need only receive message-based communication from teletypewriters (TTYs), devices which are distinct and may be incompatible with modern mobile and smartphones;^{14, 15} and

Whereas, Approximately 50 million Americans have hearing disabilities, and 7.5 million Americans have difficulty vocalizing words;^{16, 17} and

Whereas, The FCC found a majority of those with hearing and speech disabilities have discarded their TTYs in favor of mobile plans with SMS services, leaving millions with these disabilities at risk of not being able to effectively communicate with 9-1-1 operators;¹⁵ and

Whereas, Nationally, 9-1-1 call centers are not mandated to accept SMS messages (text-to-911), meaning that a citizen's locale may dictate the amount of emergency services they have access to;¹⁸ and

Whereas, The National Association of the Deaf (NAD) and the Hearing Loss Association of America (HLAA) both acknowledge that the existing 9-1-1 infrastructure limits the ability of those with deafness or hearing loss to contact emergency services;^{19, 20} and

Whereas, The NAD and HLAA both support continued modernization of 9-1-1 services, including the continued implementation of text-to-911;^{19, 20} and

Whereas, Our AMA has adopted policy encouraging guidelines that protect against the reallocation of 9-1-1 funding to unrelated programs (H-440.822), but does not currently encourage the continued modernization of 9-1-1 services; therefore be it

RESOLVED, That our American Medical Association support the funding of federal grant programs for the modernization of the 9-1-1 infrastructure, including incorporation of text to 911 technology. (New HOD Policy)

Fiscal note: Minimal - less than \$1,000.

Date Received: 09/24/18

RELEVANT AMA POLICY

Accountability of 911 Emergency Services Funding H-440.822

Our AMA encourages federal guidelines and state legislation that protects against reallocation of 911 funding to unrelated services.

Citation: Res. 220, A-17

¹³ Emergency medical services response to cardiac arrest. (2015). In R. Graham, M. McCoy & A. Schultz (Eds.), Strategies to improve cardiac arrest survival: A time to act. (pp. 190-192). National Academies Press, 500 Fifth Street, NW, Keck 360, Washington, DC 20001: National Academies Press. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK321505/>

¹⁴ Americans With Disabilities Act of 1990, Pub. L. No. 101-336, § IV (2012)

¹⁵ Federal Communications Commission. 2013. Pursuant to the Next Generation 911 Advancement Act of 2012 (Pub. L. No. 112-96 (2012)). Legal and Regulatory Framework for Next Generation 911 Services Report to Congress and Recommendations. Section 4.1.6.1.

¹⁶ Statistics on Voice, Speech, and Language. National Institute on Deafness and Other Communication Disorders. (2016, July 11). Retrieved March 28, 2018, from <https://www.nidcd.nih.gov/health/statistics/statistics-voice-speech-and-language>

¹⁷ Blackwell DL, Lucas JW, Clarke TC. Summary health statistics for U.S. adults: National Health Interview Survey, 2012. National Center for Health Statistics. Vital Health Stat 10(260). 2014.

¹⁸ Federal Communications Commission. 2017. Consumer Guide: Text-to-911: What You Need to Know. Available at <https://transition.fcc.gov/cgb/consumerfacts/text-to-911-consumer-guide.pdf>

¹⁹ National Association of the Deaf. (2018). Next generation 9-1-1 emergency services. Retrieved from <https://www.nad.org/resources/emergency-preparedness/next-generation-9-1-1-emergency-services/>

²⁰ Hearing Loss Association of America. (2018). 911. Retrieved from <http://www.hearingloss.org/content/911>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 905
(I-18)

Introduced by: Medical Student Section

Subject: Support Offering HIV Post Exposure Prophylaxis to All Survivors of Sexual Assault

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, 19.3% of women and 1.7% of men in the United States report being raped during their lifetime, and 1.8 per 1000 children have been sexually abused;¹ and

Whereas, The Centers for Disease Control and Prevention (CDC) estimates the risk of contracting HIV from a known HIV-positive person through consensual vaginal intercourse at 0.1%–0.2% and anal intercourse at 0.5%–3%, and this risk may increase during sexual assault due to injuries sustained by the individual;^{2,3} and

Whereas, Post-Exposure Prophylaxis (PEP) is antiretroviral medication (ART) taken within 72 hours of HIV exposure to prevent infection, and is extremely effective at preventing seroconversion after HIV exposure;^{4,5,6,7,8,9,10} and

Whereas, Current CDC guidelines indicate that persons with nonoccupational exposure to HIV should be offered PEP within 72 hours even if the HIV status of the exposor is unknown;^{11,12} and

¹ Arlene C. Seña et al., "Sexual Assault and Sexually Transmitted Infections in Adults, Adolescents, and Children," *Clinical Infectious Diseases* 61, no. suppl 8 (December 15, 2015): S856–64, doi:10.1093/cid/civ786.

² Jessica E Draughon, "Sexual Assault Injuries and Increased Risk of HIV Transmission.," *Advanced Emergency Nursing Journal* 34, no. 1 (2012): 82–87, doi:10.1097/TME.0b013e3182439e1a.

³ Jennifer F Klot et al., "Greentree White Paper: Sexual Violence, Genitoanal Injury, and HIV: Priorities for Research, Policy, and Practice.," *AIDS Research and Human Retroviruses* 28, no. 11 (November 2012): 1379–88, doi:10.1089/AID.2012.0273.

⁴ Réjean Thomas et al., "Adherence to Post-Exposure Prophylaxis (PEP) and Incidence of HIV Seroconversion in a Major North American Cohort," ed. Cristian Apetrei, *PLOS ONE* 10, no. 11 (November 11, 2015): e0142534, doi:10.1371/journal.pone.0142534.

⁵ M. E. Roland et al., "Seroconversion Following Nonoccupational Postexposure Prophylaxis against HIV," *Clinical Infectious Diseases* 41, no. 10 (November 15, 2005): 1507–13, doi:10.1086/497268.

⁶ Sarah J. McDougal et al., "Non-Occupational Post-Exposure Prophylaxis for HIV: 10-Year Retrospective Analysis in Seattle, Washington," ed. Roger Le Grand, *PLoS ONE* 9, no. 8 (August 20, 2014): e105030, doi:10.1371/journal.pone.0105030.

⁷ F Tissot et al., "Nonoccupational HIV Post-Exposure Prophylaxis: A 10-Year Retrospective Analysis," *HIV Medicine* 11, no. 9 (October 1, 2010): 584–92, doi:10.1111/j.1468-1293.2010.00826.x.

⁸ Trine Gulholm et al., "Non-Occupational HIV Post-Exposure Prophylaxis at a Sydney Metropolitan Sexual Health Clinic," *Sexual Health* 10, no. 5 (November 2013): 438, doi:10.1071/SH13018.

⁹ Cadi Irvine et al., "Efficacy of HIV Postexposure Prophylaxis: Systematic Review and Meta-Analysis of Nonhuman Primate Studies," *Clinical Infectious Diseases* 60, no. suppl_3 (June 1, 2015): S165–69, doi:10.1093/cid/civ069.

¹⁰ U.S. Department of Health & Human Services, "Post-Exposure Prophylaxis," 2015, <https://www.hiv.gov/hiv-basics/hiv-prevention/using-hiv-medication-to-reduce-risk/post-exposure-prophylaxis>.

¹¹ Kenneth L. Dominguez et al., "Updated Guidelines for Antiretroviral Postexposure Prophylaxis after Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV—United States, 2016," 2016, <https://stacks.cdc.gov/view/cdc/38856>.

¹² AIDS Institute Clinical Guidelines, "PEP for Victims of Sexual Assault Guideline" (Baltimore, MD: HIV Clinical Resource, 2016), <https://www.hivguidelines.org/pep-for-hiv-prevention/after-sexual-assault/>.

Whereas, Hospital emergency departments (EDs) typically serve as the primary point of care for survivors of sexual assault, accounting for approximately 65,000–90,000 emergency department visits per year;¹³ and

Whereas, Only 14.5% of assault survivors were offered PEP, and only 8.5% of uninsured assault survivors were offered PEP in a 2009 survey of 117 Los Angeles Emergency Departments;¹⁴ and

Whereas, A 2018 meta-analysis found that the nationally pooled mean of individuals who were sexually assaulted and offered PEP at studied emergency departments was 55.9%;¹⁵ and

Whereas, There is no national consensus on emergency medicine residents' education about sexual assault examinations, which results in suboptimal care for the survivors of sexual assaults;^{13,16,17,18,19} and

Whereas, A qualitative study in 2016 of sexual assault patients found that physicians neglecting to offer PEP is a major barrier to patient access, disproportionately affecting those who are homeless or uninsured;^{11,20} and

Whereas, The same study indicated that the physicians neglected to offer PEP or they provided incorrect counseling due to a lack of knowledge about state or national PEP guidelines and a 2013 study found 20% of emergency physicians were not aware CDC PEP guidelines;^{20,21} and

Whereas, The cost of PEP is between \$600-\$1000, and persons prescribed PEP after sexual assault can be reimbursed for medications and clinical care costs through state Crime Victim's Compensation Programs funded by the U.S. Department of Justice;^{22,23,24} and

¹³ Ashlesha Patel et al., "Assessing the Extent of Provision of Comprehensive Medical Care Management for Female Sexual Assault Patients in US Hospital Emergency Departments," *International Journal of Gynecology & Obstetrics* 123, no. 1 (October 2013): 24–28, doi:10.1016/j.ijgo.2013.04.014.

¹⁴ Raphael J. Landovitz, Kory B. Combs, and Judith S. Currier, "Availability of HIV Postexposure Prophylaxis Services in Los Angeles County," *Clinical Infectious Diseases* 48, no. 11 (June 1, 2009): 1624–27, doi:10.1086/598976.

¹⁵ Meredith Scannell, Tiffany Kim, and Barbara J. Guthrie, "A Meta-Analysis of HIV Postexposure Prophylaxis Among Sexually Assaulted Patients in the United States," *Journal of the Association of Nurses in AIDS Care* 29, no. 1 (January 2018): 60–69, doi:10.1016/j.jana.2017.10.004.

¹⁶ Margaret K Sande et al., "Sexual Assault Training in Emergency Medicine Residencies: A Survey of Program Directors.," *The Western Journal of Emergency Medicine* 14, no. 5 (September 2013): 461–66, doi:10.5811/westjem.2013.2.12201.

¹⁷ Samantha Schilling et al., "Testing and Treatment After Adolescent Sexual Assault in Pediatric Emergency Departments.," *Pediatrics* 136, no. 6 (December 2015): e1495–503, doi:10.1542/peds.2015-2093.

¹⁸ Monika K Goyal et al., "Enhancing the Emergency Department Approach to Pediatric Sexual Assault Care: Implementation of a Pediatric Sexual Assault Response Team Program.," *Pediatric Emergency Care* 29, no. 9 (September 2013): 969–73, doi:10.1097/PEC.0b013e3182a21a0d.

¹⁹ R. C. Merchant et al., "Compliance in Rhode Island Emergency Departments With American Academy of Pediatrics Recommendations for Adolescent Sexual Assaults," *PEDIATRICS* 121, no. 6 (June 1, 2008): e1660–67, doi:10.1542/peds.2007-3100.

²⁰ Valentina Djelaj, Debra Patterson, and Christina M. Romero, "A Qualitative Exploration of Sexual Assault Patients' Barriers to Accessing and Completing HIV Prophylaxis," *Journal of Forensic Nursing* 13, no. 2 (2017): 45–51, doi:10.1097/JFN.0000000000000153.

²¹ Allan E Rodríguez et al., "HIV Medical Providers' Perceptions of the Use of Antiretroviral Therapy as Nonoccupational Postexposure Prophylaxis in 2 Major Metropolitan Areas.," *Journal of Acquired Immune Deficiency Syndromes (1999)* 64 Suppl 1, no. 0 1 (November 1, 2013): S68–79, doi:10.1097/QAI.0b013e3182a901a2.

²² Office for Victims of Crime, "U.S. Resource Map of Crime Victim Services & Information," *Office of Justice Programs*, 2016, <https://ojp.gov/ovc/map.html>.

²³ Michigan Department of Health & Human Services, "Crime Victim Services," *Crime Victim Services*, 2018, http://www.michigan.gov/mdhhs/0,5885,7-339-71548_54783_54853---,00.html.

²⁴ Office of Epidemiology & Prevention Services, "Post-Exposure Prophylaxis (PEP) FAQs," *West Virginia Department of Health & Human Resources*, 2018, [https://dhhr.wv.gov/oeps/std-hiv-hep/needlestick/Pages/Post-ExposureProphylaxis\(PEP\)FAQs.aspx](https://dhhr.wv.gov/oeps/std-hiv-hep/needlestick/Pages/Post-ExposureProphylaxis(PEP)FAQs.aspx).

Whereas, The estimated lifetime cost for HIV treatment was \$367,134 in 2009 and \$379,668 in 2010, and the estimated medical cost saved by preventing one HIV infection is \$229,800;^{25, 26} and

Whereas, Many living with HIV may find it challenging to perform daily tasks, participate in moderate physical activities, or have the energy to engage in an active social life;²⁷ therefore be it

RESOLVED, That our American Medical Association advocate for education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines (New HOD Policy); and be it further

RESOLVED, That our AMA support increased public education about the effective use of Post-Exposure Prophylaxis for HIV (New HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-20.900 by addition and deletion as follows:

H-20.900, "HIV, Sexual Assault, and Violence"

Our AMA believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all victims survivors of sexual assault, that these victims survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained. (Modify Current HOD Policy)

Fiscal note: Minimal - less than \$1,000.

Date Received: 09/21/18

RELEVANT AMA POLICY:

E-8.1 Routine Universal Screening for HIV

Physicians primary ethical obligation is to their individual patients. However, physicians also have a long-recognized responsibility to participate in activities to protect and promote the health of the public.

Routine universal screening of adult patients for HIV helps promote the welfare of individual patients, avoid injury to third parties, and protect public health.

Medical and social advances have enhanced the benefits of knowing ones HIV status and at the same time have minimized the need for specific written informed consent prior to HIV testing. Nonetheless, the ethical tenets of respect for autonomy and informed consent require that physicians continue to seek patients informed consent, including informed refusal of HIV testing.

To protect the welfare and interests of individual patients and fulfill their public health obligations in the context of HIV, physicians should:

- (a) Support routine, universal screening of adult patients for HIV with opt-out provisions.
- (b) Make efforts to persuade reluctant patients to be screened, including explaining potential benefits to the patient and to the patients close contacts.
- (c) Continue to uphold respect for autonomy by respecting a patients informed decision to opt out.
- (d) Test patients without prior consent only in limited cases in which the harms to individual autonomy are offset by significant benefits to known third parties, such as testing to protect occupationally exposed health care professionals or patients.
- (e) Work to ensure that patients who are identified as HIV positive receive appropriate follow-up care and counseling.
- (f) Attempt to persuade patients who are identified as HIV positive to cease endangering others.

²⁵ CDC Division of HIV/AIDS Prevention, "HIV Cost-Effectiveness," *HIV/AIDS*, 2017, <https://www.cdc.gov/hiv/programresources/guidance/costeffectiveness/index.html>.

²⁶ Bruce R Schackman et al., "The Lifetime Medical Cost Savings from Preventing HIV in the United States.," *Medical Care* 53, no. 4 (April 2015): 293–301, doi:10.1097/MLR.0000000000000308.

²⁷ K H Basavaraj, M A Navya, and R Rashmi, "Quality of Life in HIV/AIDS.," *Indian Journal of Sexually Transmitted Diseases* 31, no. 2 (July 2010): 75–80, doi:10.4103/0253-7184.74971.

(g) Be aware of and adhere to state and local guidelines regarding public health reporting and disclosure of HIV status when a patient who is identified as HIV positive poses significant risk of infecting an identifiable third party. The doctor may, if permitted, notify the endangered third party without revealing the identity of the source person.

(h) Safeguard the confidentiality of patient information to the greatest extent possible when required to report HIV status.

[AMA Principles of Medical Ethics: I, VI, VII](#)

Issued: 2016

Sexual Assault Survivor Services H-80.998

Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.

Citation: Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17

HIV, Sexual Assault, and Violence H-20.900

Our AMA believes that HIV testing should be offered to all victims of sexual assault, that these victims should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained.

Citation: (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

Access to Emergency Contraception H-75.985

It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.

Citation: (CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14)

HIV Postexposure Prophylaxis for Medical Students During Electives Abroad D-295.970

Our AMA: (1) recommends that US medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV prophylaxis; and (2) encourages medical schools to provide information to medical students regarding the potential health risks of completing a medical rotation abroad, and on the appropriate precautions to take to minimize such risks.

Citation: (Res. 303, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895

1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.

Citation: Res. 106, A-16; Modified: Res. 916, I-16; Appended: Res. 101, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 906
(I-18)

Introduced by: Medical Student Section

Subject: Increased Access to Identification Cards for the Homeless Population

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, More than 3.5 million Americans will experience homelessness at some point in a given year, and 77,486 of these individuals are chronically homeless;^{1,2} and

Whereas, The AMA supports public policy initiatives pertaining to access to care, and in particular supports improving health outcomes and decreasing health care costs for the homeless population (H-160.903, H-160.798, H-345.975, H-185.944); and

Whereas, Lack of identification serves as a major barrier for homeless individuals seeking medical care, in particular preventing them from enrolling in Medicaid, with 45.1% of the homeless without photo identification denied access to Medicaid or medical services;^{3,4,5} and

Whereas, Over 36% of the U.S. homeless population suffers from a severe mental illness or chronic substance abuse, and lack of identification among the homeless prevents them from accessing drug treatment and rehabilitation programs;^{6,7} and

Whereas, Forty-three states allow for pharmacists to require photograph identification from individuals prior to dispensing prescription drugs;⁸ and

Whereas, Unsheltered homeless individuals often have poorer health, less access to healthcare, and an increased risk of premature mortality compared to the sheltered homeless;⁹ and

¹ National Law Center on Homelessness & Poverty. (2004). *Photo Identification Barriers Faced by Homeless Persons: The Impact of September 11*. Washington, DC. <https://www.nlchp.org/documents/ID_Barriers>

² Department of Housing and Urban Development. (2017). *Sheltered Homeless Persons in Detroit (MI) 10/1/2016 - 9/30/2017*. Detroit: 2017 Annual Homeless Assessment Report.

<<https://static1.squarespace.com/static/5344557fe4b0323896c3c519/t/5a7c751608522985c2a3c780/1518105882011/2017+AHAR+All+Persons+Report+FINAL+from+HDX.pdf>>

³ Michigan Commission on Community Action and Economic Opportunity. (2016). *State Identification Cards*. Michigan Department of Health and Human Services.

<https://www.michigan.gov/documents/mdhhs/Commission_Report_State_Identification_Cards_552059_7.pdf>

⁴ National Law Center on Homelessness & Poverty. (2004). *Photo Identification Barriers Faced by Homeless Persons: The Impact of September 11*. Washington, DC. <https://www.nlchp.org/documents/ID_Barriers>

⁵ Kaiser Commission on Medicaid and the Uninsured. (2012). *Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion*. Washington, DC: The Henry J. Kaiser Family Foundation. <<https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8355.pdf>>

⁶ Kaiser Commission on Medicaid and the Uninsured. (2012). *Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion*. Washington, DC: The Henry J. Kaiser Family Foundation. <<https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8355.pdf>>

⁷ Peterson JA, S. R. (2010). Why don't out-of-treatment individuals enter methadone treatment programs? The International journal on drug policy. *International Journal of Drug Policy*, (21)1:36-42.

⁸ National Alliance for Model State Drug Laws. (2018). *States that Require ID Prior to Dispensing Controlled Substances or Non-Controlled Prescription Drugs*. Charlottesville: Office of National Drug Control Policy. <<http://www.namsdl.org/library/052D1242-E158-6B44-A6E69A0729BCDF0C>>

⁹ Montgomery, A. E., Szymkowiak, D., Marcus, J., Howard, P., & Culhane, D. P. (2016). Homelessness, Unsheltered Status, and Risk Factors for Mortality: Findings From the 100 000 Homes Campaign. *Public Health Reports*, 131(6), 765-772. doi:10.1177/0033354916667501

Whereas, The National Law Center on Homelessness and Poverty found that 54.1% of homeless individuals were denied housing or shelter due to lack of identification;¹⁰ and

Whereas, Recent national surveys have shown that 28% of homeless individuals do not get enough to eat, with 40% report going one or more days without food due to the inability to afford it;¹¹ and

Whereas, Lack of identification can prevent homeless individuals who qualify for Supplemental Nutrition Assistance Program (SNAP) benefits from accessing this service, as the application process requires personal identification; as a result, only 37% of the homeless population receives SNAP benefits;¹² and

Whereas, Lack of identification causes homeless individuals to delay care due to lack of insurance, and therefore has a systemic economic impact through increased emergency department utilization and presentation in more advanced disease stages;^{13,14} and

Whereas, The Medicaid application process includes verifying the applicant's Social Security Number, yet a replacement Social Security card requires a form of identification such as driver's license, state-issued non-driver identification card, or U.S. passport;^{15,16} and

Whereas, The average application fees to obtain a birth certificate and passport in the U.S. are \$15.81 and \$97, respectively;¹⁷ and

Whereas, A national study found that 36% of homeless individuals could not obtain a photo identification because they could not afford it;¹⁸ and

Whereas, The state of California passed a law allowing homeless individuals to obtain free photo identification, and a number of other state legislatures are in the process of doing the same;^{19,20,21,22,23} therefore be it

¹⁰ National Law Center on Homelessness & Poverty. (2004). *Photo Identification Barriers Faced by Homeless Persons: The Impact of September 11*. Washington, DC. <https://www.nlchp.org/documents/ID_Barriers>

¹¹ Rosen, J., Hoey, R., & Steed, T. (2000). Food stamp and SSI benefits: Removing access barriers for homeless people. *Clearinghouse Rev.*, 34, 679.

¹² Rosen, J., Hoey, R., & Steed, T. (2000). Food stamp and SSI benefits: Removing access barriers for homeless people. *Clearinghouse Rev.*, 34, 679.

¹³ Kaiser Commission on Key Facts. (2012). *The Uninsured And The Difference Health Insurance Makes*. Washington, DC: Henry J Kaiser Family Foundation. <<https://www.kff.org/health-reform/fact-sheet/the-uninsured-and-the-difference-health-insurance/>>

¹⁴ Hwang, S., & Henderson, M. J. (2010). Health care utilization in homeless people: translating research into policy and practice. *Agency for Healthcare Research and Quality Working Paper*, (10002). <https://meps.ahrq.gov/data_files/publications/workingpapers/wp_10002.pdf>

¹⁵ Wilkins, C., Burt, M. R., & Locke, G. (2014). *A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing*. Office of the Assistant Secretary for Planning and Evaluation.

¹⁶ Social Security Administration. (2018). *Social Security Administration*. Retrieved from Learn what documents you will need to get a Social Security Card: <https://www.ssa.gov/ssnumber/ss5doc.htm>

¹⁷ Department of Homeland Security Regulatory Evaluation. (2008). *Regulatory Evaluation for REAL ID Program*. Department of Homeland Security. <<https://www.regulations.gov/document?D=DHS-2006-0030-10704>>

¹⁸ National Law Center on Homelessness & Poverty. (2004). *Photo Identification Barriers Faced by Homeless Persons: The Impact of September 11*. Washington, DC. <https://www.nlchp.org/documents/ID_Barriers>

¹⁹ State of California Department of Motor Vehicles. (2018). Is There a Fee? *FFDL 6 Requirements for a California Identification Card*. California. <https://www.dmv.ca.gov/portal/dmv/detail/pubs/brochures/fast_facts/ffd06>

²⁰ Hawaii Senate Bill 11. S 346. 29th Legislature. (2017). <<https://legiscan.com/HI/bill/SB11/2017>>

²¹ An Act to provide identification to homeless youth and families. S.1906. 190th General Court of the Commonwealth of Massachusetts. (2017). <<https://malegislature.gov/Bills/190/H2737>.html>

²² Texas House Bill 3354. Relating to the fee for a driver's license or personal identification certificate for a homeless individual. Texas House of Representatives. 85th Legislature. (2017). <<https://legiscan.com/TX/text/HB3354/id/1559665>>

²³ West Virginia H.B. 2215. West Virginia House of Representatives. (2017).

<http://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=hb2215%20intr.htm&yr=2017&sesstype=RS&i=2215>

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

4
 5 RESOLVED, That our AMA support legislative and policy changes that streamline, simplify, and
 6 reduce or eliminate the cost of obtaining identification cards for the homeless population. (New
 7 HOD Policy)

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

Date Received: 09/21/18

RELEVANT AMA POLICY

The Mentally Ill Homeless H-160.978

(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.

Citation: BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16

Eradicating Homelessness H-160.903

Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless; (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis; (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness; and (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.

Citation: Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18

Maintaining Mental Health Services by States H-345.975

Our AMA:

1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.

Citation: (Res. 116, A-12; Reaffirmation A-15)

Subscriber Identification Cards H-185.944

Our AMA: (1) urges any pertinent official or governmental agency to require health insurance plans to issue identification cards to its subscribers which prominently identify the full legal name of the insured; name of the policy holder; identification numbers needed for claim submission; and the primary insurance company name with its appropriate mailing address; and (2) will advocate for legislative and regulatory sanctions against insurance companies which present obstacles to the timely filing of claims which result in the denial of benefits.

Citation: (Sub. Res. 716, A-10; Modified: Sub. Res. 715, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 908
(I-18)

Introduced by: Medical Student Section

Subject: Increasing Accessibility to Incontinence Products

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, As sales of adult incontinence products and baby diapers are projected to increase 48% and 2.6% respectively by 2020, more individuals and families in both populations face similar challenges to accessing necessary incontinence products;¹ and

Whereas, Lack of access to necessary incontinence products leads to prolonged use of soiled diapers, which precipitates health problems including recurrent urinary tract infections, diaper dermatitis, or exacerbation of eczema, leading to an increase in physician's office and emergency room visits;^{2,3} and

Whereas, Diaper need, defined as lacking the financial means to purchase an adequate supply of diapers, is a widespread issue affecting parents of all ethnicities and economic statuses, especially those living below the poverty line;⁴ and

Whereas, Among children using diapers, 23% are members of families earning less than 100% of the federal poverty level and an additional 23% live in families earning 100% to 200% of the federal poverty level;^{1,5} and

Whereas, The national average cost of diapers is \$936 annually, the equivalent of 14% of national average annual income;^{2,6} and

Whereas, Diaper need occurs more frequently in parents with mental health needs and contributes to parental stress and depression, factors which in turn have been known to increase the risk of a child's future behavioral, social, and emotional problems;^{3,4} and

Whereas, Adult incontinence product use is increasing, with the Urology Care Foundation estimating that 25% to 33% of all people in the U.S. suffer from some degree of urinary incontinence, with more than 50% of individuals over 65 having experienced incontinence;^{7,8} and

¹ Hymowitz C, Lochner-Coleman L. The Adult Diaper Market is About to Take Off. *Bloomberg*. February 11, 2016.

² Porter S, Steelfel L. Diaper need: A change for better health. *Pediatric Nursing*. 2015;41(3):141.

³ Fujimura T, Makino M, Takagi M, et al. The influence of incontinence on the characteristic properties of the skin in bedridden elderly subjects. *International Journal of Dermatology*. 2016;55(5):e234-240.

⁴ Raver C, Letourneau N, Scott J, D'Agostino H. Huggies every little bottom study: Diaper need in the US and Canada. Commissioned by Huggies®, a Kimberly-Clark company. 2010.

⁵ Diaper Need in America. National Diaper Bank Network. Accessed at <https://nationaldiaperbanknetwork.org/what-is-diaper-need/>.

⁶ Smith MV, Kruse A, Weir A, Goldblum J. Diaper need and its impact on child health. *Pediatrics*. 2013;132(2):253.

⁷ Urology Care Foundation: What is urinary incontinence? <https://www.urologyhealth.org/urologic-conditions/urinary-incontinence>. Accessed March 26, 2018.

⁸ Alameda County Board of Supervisors. Legislative Position Request Form. January 11, 2016.

Whereas, Of the 43 million Americans over 65 years of age, 9.4% are living below the federal poverty level;⁹ and

Whereas, Seniors can expect to spend approximately \$1800 annually on adult diapers, and for low-income individuals this expense “can consume over 10 percent of their annual income”;⁹ and

Whereas, Studies have found that incontinence is detrimental to quality of life through its impact on relationships, self-esteem, employment, travel, and social activities;^{10,11,12} and

Whereas, 18 states have already eliminated sales tax on adult incontinence products and 13 states have eliminated sales tax on diapers by classifying them as medical supplies or clothing, exempting them as medical prescriptions, or having no sales tax at all;²¹ and

Whereas, 32 states still charge sales tax on adult incontinence products and 37 states still charge sales tax on diapers, with the sales tax as high as 7.25 percent;¹³ and

Whereas, Multiple pieces of state and federal legislation have proposed to increase access to adult incontinence products and diapers by removing state taxes, aiding low-income families in purchasing necessary products, and increasing insurance coverage through Medicare and Medicaid; however none have currently passed;^{14,15,16,17,18} and

Whereas, Our AMA already supports the removal of all sales tax on feminine hygiene products in order to increase access to necessary medical products, especially for those who live below the federal poverty line (H-270.953); therefore be it

RESOLVED, That our American Medical Association support increased access to affordable incontinence products. (New HOD Policy)

Fiscal note: Minimal - less than \$1,000.

Received: 09/24/18

⁹ Alameda County Board of Supervisors. Legislative Position Request Form. January 11, 2016.

¹⁰ Fisher, K. et al. Comparison of Recall and Daily Self-Report of Fecal Incontinence Severity. J Wound Ostomy Continence Nurs. 2008 Sept-Oct;35(5):515-20.

¹¹ Alimohammadian, M. et al. Suffering in silence: a community-based study of fecal incontinence in women. Int J Colorectal Dis. 2014 Mar;29(3):401-6.

¹² Halland, M. et al. Prevalence correlates and impact of fecal incontinence among older women. Dis Colon Rectum. 2013 Sep;56(9): 1080-6.

¹³ Weir, AM. Fifty state survey on the sales tax treatment of diapers. *National Diaper Bank Network*. January 9, 2017.

¹⁴ Hellmann J. Illinois lawmaker wants to cut tax on diapers, baby wipes. *Chicago Tribune*. February 6, 2015.

¹⁵ Coffey D. Legislators seek to make diapers exempt from state sales tax. *Hartford Courant*. February 2, 2015.

¹⁶ Vitale, Joseph F. State Concurrent Resolution No. 53. State of New Jersey. Introduced January 16, 2018.

¹⁷ Hygiene Assistance for Families of Infants and Toddlers Act of 2016, S. S.3070, 114 Cong. June 16, 2016.

¹⁸ Hygiene Assistance for Families of Infants and Toddlers Act of 2015, H.R. H.R.4055, 114th Cong. November 18, 2015.

RELEVANT AMA POLICY:

Tax Exemptions for Feminine Hygiene Products H-270.953

Our AMA supports legislation to remove all sales tax on feminine hygiene products.

Citation: Res. 215, A-16

Insurance Coverage for Complete Maternity Care H-185.997

Our AMA (1) reaffirms its policy of encouraging health insurance coverage for care of the newborn from the moment of birth;

(2) urges the health insurance industry and government to include in their plans, which provide maternity benefits, coverage for normal obstetrical care, and all obstetrical complications including necessary intrauterine evaluation and care of the unborn infant;

(3) urges the health insurance industry to offer such plans on the broadest possible basis;

(4) urges the health insurance industry to make available, on an optional basis, coverage for treatment associated with voluntary control of reproduction;

(5) will advocate for expanding coverage of maternity care to dependent women under the age of 26 on their parents' large group plans; and

(6) will advocate that individual, small and large group health plans provide 60 days of newborn coverage for all newborns born to participants in the plan.

Citation: (BOT Rep. M, CMS Rep. J, I-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 103, A-09; Appended: Res. 101, A-14)

Opposition to Proposed Budget Cuts in WIC and Head Start H-245.979

The AMA opposes reductions in funding for WIC and Head Start and other programs that significantly impact child and infant health and education.

Citation: (Res. 246, I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14)

Expanding Enrollment for the State Children's Health Insurance Program (SCHIP) H-290.971

Our AMA continues to support:

a. health insurance coverage of all children as a strategic priority;

b. efforts to expand coverage to uninsured children who are eligible for the State Children's Health Insurance Program (SCHIP) and Medicaid through improved and streamlined enrollment mechanisms;

c. the reauthorization of SCHIP in 2007; and

d. supports the use of enrollment information for participation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and/or the federal school lunch assistance program as documentation for SCHIP eligibility in order to allow families to avoid duplication and the cumbersome process of re-documenting income for child health coverage.

Citation: (Res. 118, A-07; CMS Rep. 1, A-07; Reaffirmation A-14)

Adequate Funding of the WIC Program H-245.989

Our AMA urges the U.S. Congress to investigate recent increases in the cost of infant formula, as well as insure that WIC programs receive adequate funds to provide infant formula and foods for eligible children.

Citation: (Res. 269, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10)

Dignity and Self Respect H-25.997

The AMA believes that medical care should be available to all our citizens, regardless of age or ability to pay, and believes ardently in helping those who need help to finance their medical care costs.

Furthermore, the AMA believes in preserving dignity and self respect of all individuals at all ages and believes that people should not be set apart or isolated on the basis of age. The AMA believes that the experience, perspective, wisdom and skill of individuals of all ages should be utilized to the fullest.

Citation: AMA President's Address, A-61; Reaffirmed: CLRPD C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Modified: CEJA Rep. 06, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 911
(I-18)

Introduced by: Resident and Fellow Section

Subject: Regulating Tattoo and Permanent Makeup Inks

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 Whereas, Almost a fourth of men and women between the age of 18 and 50 currently have a
2 tattoo¹; and
3

4 Whereas, The Food and Drug Administration regulates cosmetics, which are generally pigments
5 used on the surface of the skin, but does not regulate tattoo and permanent makeup inks which
6 are pigments injected with needles below the skin's surface²; and
7

8 Whereas, Some risks, such as the spread of infections through the use of unsterilized needles,
9 have long been known²; and
10

11 Whereas, The long term safety of permanent tattoo inks has not been previously studied²; and
12

13 Whereas, Research has also shown that some pigment migrates from the tattoo site to the
14 body's lymph nodes²; and
15

16 Whereas, Many pigments used in tattoo inks are industrial-grade colors suitable for printers' ink
17 or automobile paint²; and
18

19 Whereas, Azo pigments, the organic pigments making up about 60% of the colorants in tattoo
20 inks are not of health concern while chemically intact, they can degrade with the help of bacteria
21 or ultraviolet light and potentially can turn into cancer-causing primary aromatic amines; and
22

23 Whereas, Some surveys show that up to 50% of tattoo owners come to regret getting a tattoo;
24 and
25

26 Whereas, Lasers are often used to blast apart pigments, sending problematic degradation
27 products into the body and researchers do not know how the degradation products are
28 distributed in the body or how they get excreted; and
29

30 Whereas, A study by the Australian government's National Industrial Chemical's Notification and
31 Assessment Scheme (NICNAS) showed the presence of polycyclic aromatic hydrocarbons
32 (PAHs), a group of chemicals known to be carcinogens in more than one-fifth of 49 inks tested
33 and in 83% of the black inks tested³; and
34

35 Whereas, Tattoo inks may also contain potentially harmful metal impurities such as chromium,
36 nickel, copper, and cobalt; and
37

38 Whereas, Manufacturers of tattoo and permanent makeup inks in the United States are often
39 protected from divulging the ingredients of tattoo inks under the guise of considering them
40 'trademark secrets'; and

Whereas, In 2008, the Council of Europe, an organization focused on promoting human rights and the integration of regulatory functions in the continent, recommended policies to ensure the safety of tattoos and permanent makeup, which advocate the banning of sixty-two hazardous chemicals, as well as guidelines which include that tattoo and permanent makeup products should contain the following information on the packaging: the name and address of the manufacturer or the person responsible for placing the product on the market, the date of minimum durability⁴, the conditions of use and warnings, the batch number or other reference used by the manufacturer for batch identification, the list of ingredients according to their International Union of Pure and Applied Chemistry (IUPAC) name, CAS Number (chemical Abstract Service of the American Chemical Society) or Colour index (CI) number, and the guarantee of sterility of the contents⁵; and

Whereas, AMA policy H-440.909, "Regulation of Tattoo Artists and Facilities," currently only encourages the state regulation of tattoo artists and tattoo facilities to ensure adequate procedures to protect the public health, and encourages physicians to report all adverse reactions associated with tattooing to the Food and Drug Administration MedWatch program; and

Whereas, Current regulation of tattoo and permanent makeup inks in the United States performed at state or provincial levels generate a wide variety of guidelines and hygiene standards; therefore be it

RESOLVED, That our American Medical Association encourage the Food and Drug Administration to adopt regulatory standards for tattoo and permanent makeup inks that include at minimum the disclosures expected for injectable drugs and cosmetics and mandate that this information be available to both the body licensed to perform the tattoo and to the person receiving the tattoo (New HOD Policy); and be it further

RESOLVED, That our AMA study the safety of any chemical in tattoo and permanent makeup inks. (Directive to Take Action)

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

Received: 09/27/18

References:

¹ Laumann AE, Derick AJ. Tattoos and body piercings in the United States: a national data set. *Journal of the American Academy of Dermatology*. 2006 Sep 30;55(3):413-21.

² <https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm048919.htm>

³ <http://theconversation.com/one-in-five-tattoo-inks-in-australia-contain-carcinogenic-chemicals-63947>

⁴ Laumann AE, Derick AJ. Tattoos and body piercings in the United States: a national data set. *Journal of the American Academy of Dermatology*. 2006 Sep 30;55(3):413-21.

⁵ https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805d3dc4

RELEVANT AMA POLICY

H-440.909 Regulation of Tattoo Artists and Facilities

The AMA encourages the state regulation of tattoo artists and tattoo facilities to ensure adequate procedures to protect the public health; and encourages physicians to report all adverse reactions associated with tattooing to the Food and Drug Administration MedWatch program. (Res. 506, A-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16)

H-440.934 Adequacy of Sterilization in Commercial Enterprises

The AMA requests that state health departments ensure the adequacy of sterilization of instruments used in commercial enterprises (tattoo parlors, beauty salons, barbers, manicurists, etc.) because of the danger of exchange of infected blood-contaminated fluids. (Sub. Res. 409, I-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 912
(I-18)

Introduced by: Resident and Fellow Section

Subject: Comprehensive Breast Cancer Treatment

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, The Women's Health and Cancer Rights Act of 1998 (WHCRA) mandates that insurance providers cover reconstructive procedures after mastectomy; and

Whereas, Some insurers have interpreted this language as only covering total mastectomies and not partial mastectomies or lumpectomies and thus deny coverage of reconstructive surgery for patients with deformities after lumpectomies and after radiation; and

Whereas, Breast conservation therapy is often an oncologically safe option for patients, which may leave the breast disfigured; and

Whereas, Radiation therapy in and of itself can lead to pain, fibrosis and deformity of a post-treatment breast; and

Whereas, Technology and techniques for correcting post-lumpectomy and post-radiation deformities have improved and increased, yet insurance interpretation of the WHCRA benefit may limit women's access to corrective surgery, oncoplastic reconstruction and fat grafting; and

Whereas, Breast reconstruction has been shown to significantly increase physical, social and sexual well-being¹; therefore be it

RESOLVED, That our AMA amend Policy H-55.973, "Breast Reconstruction," by addition and deletion as follows:

Our AMA: (1) believes that reconstruction of the breast for rehabilitation of the ~~postmastectomy cancer~~ post-treatment patient with in situ or invasive breast neoplasm should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided. (Modify Current HOD Policy)

References:

¹ [Eltahir Y¹](#), [Werners LL](#), [Dreise MM](#), [van Emmichoven IA](#), [Jansen L](#), [Werker PM](#), de Bock GH. Quality-of-life outcomes between mastectomy alone and breast reconstruction: comparison of patient-reported BREAST-Q and other health-related quality-of-life measures. [Plast Reconstr Surg](#). 2013 Aug;132(2):201e-209e. doi: 10.1097/PRS.0b013e31829586a7.

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

Received: 09/27/18

RELEVANT AMA POLICY

Breast Reconstruction H-55.973

Our AMA: (1) believes that reconstruction of the breast for rehabilitation of the postmastectomy cancer patient should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided.

CCB/CLRPD Rep. 3, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 913
(I-18)

Introduced by: Women Physicians Section

Subject: Addressing the Public Health Implications of Pornography

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 Whereas, Pornography is now recognized as a factor that directly contributes to and increases
2 all forms of violence against women as well as violence against children¹⁻¹⁷; and
3

4 Whereas, Exposure to pornography has been demonstrated to increase the likelihood of
5 perpetration of violence, including rape, domestic violence, and sexual harassment¹⁻¹⁷; and
6

7 Whereas, Literature shows that pornography demonstrably teaches beliefs about women,
8 children, and interpersonal relationships and teaches pathological and/or illegal sexual
9 behaviors (including rape, child molestation, prostitution, domestic violence, pedophilia, sexual
10 harassment, and some paraphilias)⁴⁻⁷; and
11

12 Whereas, Data demonstrate that pornography normalizes and promotes these pathological
13 and/or illegal behaviors^{1-3, 18-23}; and
14

15 Whereas, Digital access allows average age of first pornography exposure in the early teens
16 during a crucial stage of sexual development in young people⁸⁻¹⁷; and
17

18 Whereas, Pornography can also promote behaviors that increase the risk of sexually
19 transmitted diseases, gastrointestinal fissures/ruptures, post-traumatic stress disorder, sex
20 addiction, and paraphilias¹⁸⁻²³; and
21

22 Whereas, Four states (Florida, Idaho, Kansas, and Utah) have declared pornography to be a
23 public health risk²⁴; therefore be it
24

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

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

Received: 09/28/18

References:

1. Marshall, W. L. (2000). Revisiting the use of pornography by sexual offenders: Implications for theory and practice. *The Journal of Sexual Aggression*, 6, 67-77.
2. Ohbuchi, K. Ikeda, T. & Takeuchi, G. (1994). Effects of violent pornography upon viewers rape myth beliefs: A study of Japanese males. *Psychology, Crime & Law*, 1, 71-81.
3. Allen, M., Emmers, T., Gebhardt, L., & Giery, M. (1995). Exposure to pornography and acceptance of the rape myth. *Journal of Communication*, 45, 1, 5-26.
4. Barak, A., Fisher, W. A., Belfry, S., & Lashambe, D. R. (1999). Sex, guys, and cyberspace: Effects of internet pornography and individual differences on men's attitudes toward women. *Journal of Psychology and Human Sexuality*, 11, 63-92.
5. Shope, J. (2004). When words are not enough: The search for the effect of pornography on abused women. *Violence Against Women*, 10, 1, 56-72.
6. Simmons, C. A., Lehmann, P. & Collier-Tennison, S. (2008). Linking male use of the sex industry to controlling behaviors in violent relationships: An exploratory analysis. *Violence Against Women*, 14, 406-417.
7. Sommers, E. K. & Check, J. V. P. (1987). An empirical investigation of the role of pornography in the verbal and physical abuse of women. *Violence and Victims*, 2(1), 189- 209.
8. Allen, M., D'Alessio, D., & Brezgel, K. (1995). A meta-analysis summarizing the effects of pornography II: Aggression after exposure. *Human Communication Research*, 22, 258- 283.
9. Boeringer, S. B. (1994). Pornography and sexual aggression: Associations of violent and nonviolent depictions with rape and rape proclivity. *Deviant Behavior*, 15, 289-304
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14. Koss, M., & Oros, C. (1982). Sexual experiences survey: A research instrument investigating sexual aggression and victimization. *Journal of Consulting and Clinical Psychology*, 50, 455-457.
15. Malamuth, N., Addison, T. & Koss, M. (2000). Pornography and sexual aggression: Are there reliable effects and can we understand them? *Annual Review of Sex Research*.
16. Bergen, R. & Bogle, K. (2000). Exploring the connection between pornography and sexual violence. *Violence and Victims*, 15, 3, 227-234.
17. Allen, M., D'Alessio, D., & Brezgel, K. (1995). A meta-analysis summarizing the effects of pornography II: Aggression after exposure. *Human Communication Research*, 22, 258- 283.
18. Weaver, J., Masland, J. L., & Zillmann, D. (1984). Effect of erotica on young men's aesthetic perception of their female sexual partners. *Perceptual and Motor Skills*, 58, 929- 930.
19. Zillmann, D. & Bryant, J. (1988). Pornography's impact on sexual satisfaction. *Journal of Applied Social Psychology*, 18, 438-453.
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21. Carroll, J. S., Padilla-Walker, L. M., Nelson, L. J., Olson, C. D., Barry, C. M., & Madsen, S. (2008). Generation XXX: Pornography acceptance and use among emerging adults. *Journal of Adolescent Research*, 23, 1, 6-30.
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23. Zillmann, D. & J. Bryant. (1984). Effects of massive exposure to pornography. In Malamuth, N and Donnerstein, E. (Eds), *Pornography and sexual aggression*. San Diego, Academic Press. (pp. 127-158). Hillsdale, NJ: Erlbaum.
24. Is Pornography a 'Public Health Risk'? Available at <https://www.healthline.com/health-news/is-pornography-a-public-health-risk#1>.

RELEVANT AMA POLICY

Child Pornography H-60.990

The AMA (1) encourages and promotes awareness of child pornography issues among physicians; (2) promotes physician awareness of the need for follow-up psychiatric treatment for all victims of child pornography; (3) encourages research on child abuse (including risk factors, psychological and behavioral impact, and treatment efficacy) and dissemination of the findings; and (4) wherever possible, encourages international cooperation among medical societies to be alert to and intervene in child pornography activities.

Citation: BOT Rep. Z, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934

Our AMA:

- (1) Recognizes the positive role of the Internet in providing health information to children and youth.
- (2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
- (3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.
- (4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.
- (5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.

Citation: BOT Rep. 10, I-06; Modified: CSAPH Rep. 01, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 914
(I-18)

Introduced by: American Association of Public Health Physicians

Subject: Common Sense Strategy for Tobacco Control and Harm Reduction

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 Whereas, In the last few decades the United States has achieved remarkable success in
2 reducing the use of tobacco products and the associated negative health consequences; and
3

4 Whereas, From a common sense perspective, most would agree that in the case of an
5 individual smoking tobacco vs. e-cigs, the tobacco smoke produces more harmful tars and
6 toxins and individuals have the right to try to switch to e-cigs to reduce inhaling these; and
7

8 Whereas, Many physicians believe that because of the addictive - and possible acute
9 inflammatory effects of nicotine on the cardiovascular system - patients be encouraged to try to
10 stop smoking by other means before using e-cigs; and
11

12 Whereas, Teens and young adults, up to 21 years of age should avoid all nicotine delivery
13 products because of the risks of addiction and adverse effects on brain development; and
14

15 Whereas, The strong divide in the medical and public health communities regarding accessibility
16 of e-cigs, primarily rests on "population" based disagreements and speculations regarding
17 whether they are effective for the complete abstinence from smoking cigarettes, will prove
18 effective over the long term in reducing tobacco use and whether they play a role in addicting
19 youth to nicotine, and possibly tobacco; and
20

21 Whereas, Recent debate over the role of inhalation products in further tobacco harm reduction
22 has created confusion within the profession and public, rather than the sage guidance they
23 deserve; and
24

25 Whereas, E-cigarettes have been shown to be effective in reducing tobacco use in some adults
26 justifying them as a cessation option, yet, it is also prudent to assure minors are banned from
27 purchasing potentially addictive nicotine substances; and
28

29 Whereas, Although abstinence of inhalation of other than prescribed drugs is the healthiest
30 practice, youth continue to experiment with inhalation of substances such as cannabis, corn silk,
31 hookah mixtures and non-drug containing, relatively toxic free, often flavored, "vape" products;
32 therefore be it

1 RESOLVED, That our American Medical Association advocate for a "protect adult choice and
2 youth's health" "common sense" tobacco strategy (with a report back to the House of Delegates
3 annually) under which:
4

- 5 • Current educational, promotional and policy initiatives (e.g. taxation) to reduce the
6 use of tobacco products by inhalation and orally would continue, including
7 advocating for the prohibition of the sale of ALL nicotine containing products to
8 individuals under 21 years unless via prescription for medical purposes.
9
- 10 • E-cigarettes (non-tobacco products containing nicotine) would be accessible at an
11 affordable price to adults who wish to use them, and would be available to
12 individuals below 21 years of age only as part of state sanctioned tobacco
13 cessation activities. States and local jurisdictions would be free to require vendors
14 to post warnings regarding the possible health risks of the use of nicotine inhalation
15 products.
16
- 17 • Non-nicotine, non-drug containing vaping and other inhalation products would not
18 be considered tobacco products, but would be monitored by state and local
19 jurisdictions as any other personal use product regarding safety and public
20 accommodation. (New HOD Policy)

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

Received: 09/28/18

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

REPORT OF THE BOARD OF TRUSTEES

B of T Report 2-I-18

Subject: Redefining AMA's Position on ACA and Healthcare Reform

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

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform," which called on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on a number of specific issues related to the Affordable Care Act (ACA) and health care reform. The adopted policy went on to call for our AMA to report back at each meeting of the HOD. BOT Report 6-I-13, "Redefining AMA's Position on ACA and Healthcare Reform," accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

EFFORTS TO REPEAL THE ACA

Following the failure of Congress to repeal the Affordable Care Act, the Administration has continued to take steps to undermine the law or provide coverage options outside of the ACA exchanges which could have the impact of weakening the individual market. Previously, the Administration had decided to discontinue payment of cost-sharing reduction benefits to support required premium support for low income individuals enrolled in the ACA exchanges. Other recent actions have included:

- On June 7, 2018, the Department of Justice filed a brief declining to defend the ACA in a case (Texas v. United States) brought by 20 state attorneys general. A week later, our AMA and four physician specialty associations filed an Amicus Brief urging the court to reject the effort to undermine the ACA. In announcing the filing, the AMA noted that "if the lawsuit were successful, federal policy could roll back to 2009, which would be remarkably disruptive to our nation's health system and every single American." It would void protections for those with pre-existing conditions, and provisions that allow children to remain on their parents' plan until age 26. Insurers would no longer be held to the 85 percent medical loss ratio, meaning they could generate higher profits at the expense of coverage and payments for services, and 100 percent coverage for certain preventive services would cease. Furthermore, annual and lifetime dollar limits could be reinstated, leading to more bankruptcies due to health care costs.
- Following on an earlier Executive Order and proposed rulemaking, the Department of Labor on June 19 issued a final rule that would allow more small employers and individuals to form Association Health Plans (AHPs). The Congressional Budget Office has estimated that most individuals in AHPs will be healthier and have higher incomes than individuals in the ACA exchanges, potentially driving up premiums in the exchanges. In comments on the proposed rule, our AMA noted support for increasing health plan choices for individuals and small businesses seeking coverage in the individual and small group markets, but expressed concern that the plans outlined in the proposed rule fell short of maintaining crucial state and federal patient and provider protections and could result in substandard health coverage. Our AMA also expressed concern over the preemption of state insurance laws and the potential for insolvent and fraudulent AHPs. On July 26, attorneys general of 14 states challenged the rule

- 1 in the U.S. District Court for the District of Columbia alleging that changing the definition of
 2 employer is inconsistent with the ACA and is a violation of the Administrative Procedures Act.
- 3 • The Centers for Medicare & Medicaid Services (CMS) announced on July 7, 2018, a delay of
 4 ACA risk adjustments for 2017. As noted in a July 16 letter opposing the decision, the risk
 5 adjustment program protects insurers from unanticipated costs in the event their enrollees are
 6 less healthy by transferring funds from plans with healthier enrollees. It is the only ACA
 7 premium stabilization program that is permanent. The letter was signed by our AMA and 27
 8 other organizations representing physicians, hospitals, and patients. Members of both parties in
 9 Congress also expressed concern with the decision. Late on July 24, CMS announced that the
 10 program would be reinstated following changes to the methodology that had played a part in
 11 the decision to suspend the program.
 - 12 • On July 10, CMS announced a significant cut to funding for consumer enrollment assistance
 13 and outreach through the navigator program. Funding for the 34 states with ACA federal
 14 market places was cut to \$10 million, 80 percent less than just two years previous. Again, the
 15 patient and provider community came together to protest this action. On July 26, 190
 16 organizations, including the AMA, wrote HHS Secretary Alex Azar and CMS administrator
 17 Seema Verma protesting the decision and urging the restoration of outreach funding.
 - 18 • On August 1, the Administration gave the go ahead for short-term limited-duration plans of
 19 364 days, with renewals allowed for up to 36 months. The plans would not be required to
 20 comply with ACA protections such as coverage for pre-existing conditions or provide for
 21 comprehensive benefits. In earlier comments urging withdrawal of the proposal, our AMA had
 22 expressed support for the goal of increasing health plan choices but warned that the proposal
 23 would undercut crucial state and federal patient protections, disrupt and destabilize the
 24 individual market and result in substandard, inadequate health insurance coverage.

25
 26 REPEAL AND APPROPRIATE REPLACEMENT OF THE SGR AND PAY-FOR-
 27 PERFORMANCE
 28

29 On July 12, CMS released a proposed rule for calendar year 2019 addressing both the Medicare
 30 Physician Fee Schedule and the Quality Payment Program. In addition to the implementation of
 31 Medicare Access and CHIP Reauthorization Act (MACRA) modifications enacted as part of the
 32 Bipartisan Budget Act of 2018 (BBA18), discussed in a previous edition of this report, there are a
 33 number of additional positive elements in the 2019 Proposed Rule. These include:
 34

- 35 • Reduced documentation burden for Evaluation & Management (E&M) office visit codes,
 36 though at this time, the degree of actual burden reduction is uncertain.
- 37 • New payments for physician services that are not part of a face-to-face visit (virtual check-ins
 38 with patients, remote consults with patients using videos/photographs, online consults with
 39 other physicians).
- 40 • Continuation of low volume threshold policy to exempt small practices from the Merit-based
 41 Incentive Payment System (MIPS).
- 42 • A reduction in problematic measures in the Promoting Interoperability provisions (formerly
 43 Meaningful Use and Advancing Care Information).

44
 45 There are, however, areas of concern where the AMA will be recommending changes, including:
 46

- 47 • E&M coding and related policies (add-on codes, multiple same day service reduction).
- 48 • AMA will urge reductions in quality measure requirements to reflect reductions in available
 49 quality measures.
- 50 • Simplifying the MIPS scoring framework to make it more clinically relevant and
 51 understandable for physicians.

- Keeping the cost category weight at 10 percent rather than increasing it to 15 percent.

The AMA is working closely with national, state and other physician groups to address widespread concerns with the proposed E&M coding changes. As part of our standard process to respond to major policy proposals our AMA is working with national specialty, state and other physician groups to develop recommendations that have broad support across the profession. A joint working group of CPT and RUC experts has been formed to develop recommendations for adjusting E&M coding policies. Given the complexity in this space, a coding change application may not be finalized until early November that may be voted on by the CPT Editorial Panel in early February. While the E&M coding issues have become a major focus, there are many important issues as part of the QPP or MACRA implementation that will have a significant impact on physician practices.

On July 24, 2018, AMA Immediate Past President David O. Barbe, MD, MHA, testified before the Health Subcommittee of the U.S. House of Representatives Committee on Energy and Commerce on the topic of “MACRA and MIPS: An Update on the Merit-based Incentive Payment System.” Dr. Barbe reminded the committee members that, despite challenges in implementing the MACRA reforms, they continue to be a significant improvement over the previous SGR update system and other legacy programs that were in place prior to MACRA. While the AMA has expressed support for recent improvements to MACRA, including those implemented as part of BBA18, we recognize the need for continued improvements to move further in the direction of choice, flexibility, simplicity and feasibility. These include further simplification and harmonization of the four separate components of MIPS. The AMA will continue to work with Congress and the Administration to refine the current system.

REPEAL AND REPLACE THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

The Bipartisan Budget Act of 2018 also repealed the IPAB which was to have been established under provisions of the ACA. Prior to its repeal, no appointments had ever been made to IPAB and the requirement for recommendations for Medicare cuts by the board was never triggered.

SUPPORT FOR MEDICAL SAVINGS ACCOUNTS, FLEXIBLE SPENDING ACCOUNTS, AND THE MEDICARE PATIENT EMPOWERMENT ACT

On July 11, 2018, the House Committee on Ways and Means reported 10 separate pieces of legislation to promote the use of consumer directed health care plans, including health savings accounts. After review, our AMA expressed support for eight of the proposals which were consistent with policies adopted by the House of Delegates.

On July 25, the full U.S. House of Representatives considered two bills which had been modified to substantially include the subject matter of nine of the bills previously considered by the Committee on Ways and Means.

H.R. 6199, the “Restoring Access to Medication and Modernizing Health Savings Accounts Act of 2018,” passed the House by a vote of 277-142. The underlying bill accomplished a long-supported AMA policy of restoring the ability of consumers to use HSAs, MSAs and HRAs to purchase over the counter drugs and expanded that policy to include feminine hygiene products as qualified expenses. Additionally, the bill adopted by the House allows those accounts to be used for the purchase of gym memberships and equipment, within certain limits; allows high-deductible plans to cover as much as \$250 of non-preventive care before the deductible is met; and allows individuals to keep eligibility for an HSA while maintaining a direct primary care service arrangement and, within limits, use HSA funds for those arrangements. The adopted bill also

1 excludes some items and services from being considered as other coverage if provided at an
2 employer-owned or retail clinic; allows transfer of funds from an FSA or HRA to an HSA under
3 certain circumstances; and allows individuals to maintain eligibility for an HSA if their spouse had
4 coverage under an FSA as long as the FSA is limited to expenses incurred by the spouse.

5
6 H.R. 6311, Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts
7 Act of 2018, passed the House by a vote of 242-176. The bill would delay for another two years the
8 Health Insurance Tax imposed by the ACA. It would also allow anyone to purchase a catastrophic
9 plan, as opposed to the current limitation to those under age 30 or with specific hardship
10 conditions. The bill increases allowed HSA contributions to match the maximum in allowed out-of-
11 pocket costs and would allow bronze and catastrophic plans offered through ACA exchanges to be
12 used with an HSA. H.R. 6311 also allows beneficiaries enrolled only in Medicare Part A to
13 contribute to an HSA and allows FSA balances to be carried over to subsequent years, though any
14 contribution limits for the next year would be lowered by the amount over \$500 that was carried
15 over.

16
17 At this writing, the potential for Senate consideration is not clear.

18 19 STEPS TO LOWER HEALTH CARE COSTS

20
21 Our AMA continues to engage with Congress and the Administration on a wide range of efforts
22 designed to lower health care costs. Ongoing efforts to address the cost of prescription drugs
23 remain among the highest profile of these efforts. On July 16, the AMA filed comments on the
24 Administration's "Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs." In the
25 comments, AMA noted that "patients are increasingly taking greater clinical risks when treatments
26 are cost prohibitive." AMA comments, which are available on the AMA website, addressed a wide
27 range of cost drivers, including issues related to competition, transparency, the Part B drug benefit
28 program, value-based pricing, and the 340B discount program.

29
30 During June and July, the Senate Committee on Health, Education, Labor and Pensions held a
31 series of hearings on reducing health care costs focusing on rural health cost drivers, administrative
32 costs, the role of quality and value in reducing excess spending. The AMA remains engaged in
33 conversation with the committee as well as in other Congressional efforts to address the impact of
34 administrative and regulatory costs and improve transparency of health care costs.

35 36 REPEAL NON-PHYSICIAN PROVIDER NON-DISCRIMINATION PROVISIONS OF THE ACA

37
38 Guidance released by the Department of Health and Human Services in 2014 included a positive
39 interpretation of health plan requirements under section 2706(a) of the ACA, specifically clarifying
40 that the section does not require "that a group health plan or health insurance issuer contract with
41 any provider willing to abide by the terms and conditions for participation." Nevertheless, the
42 AMA will continue to seek legislative opportunities to repeal this provision.

43 44 CONCLUSION

45
46 Our AMA will remain engaged in efforts to improve the health care system through policies
47 outlined in D-165.938 and other directives of the House of Delegates.

REPORT 3 OF THE BOARD OF TRUSTEES (I-18)
2018 AMA Advocacy Efforts

EXECUTIVE SUMMARY

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

The AMA was a strong and effective advocate once again for our nation’s patients and physicians this year. The AMA advanced HOD-developed policy on numerous issues. Key victories for the AMA and the Federation of Medicine include:

- Convincing Anthem to reverse course on its Modifier 25 proposal which averted cuts of \$100 million in annual payments to physician practices;
- Legislative improvements to the Quality Payment Program (QPP) which will ease physicians’ QPP transition;
- Repeal of the Independent Payment Advisory Board (IPAB);
- Reauthorization of the Children’s Health Insurance Program (CHIP) for 10 years;
- Progress on key recommendations from the AMA Opioid Task Force regarding physician prescribing, physician education, use of prescription drug monitoring programs (PDMPs), and naloxone prescription availability;
- More than 60 state-level victories in collaboration with the Federation on key issues including opioids, insurer practices, and scope of practice;
- Release of the Economic Impact Statement report, which gives policymakers concrete evidence demonstrating how their local communities tangibly benefit when they support legislation that helps physician practices thrive; and
- Over 2 million grassroots engagements through social media to advance the AMA advocacy agenda.

Staff note: This report was prepared in September 2018, and may be updated prior to the Interim Meeting based on more recent advocacy developments.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 3-I-18

Subject: 2018 AMA Advocacy Efforts

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

1 BACKGROUND

2

3 Policy G-640.005, “AMA Advocacy Analysis,” calls on the Board of Trustees (BOT) to provide a
4 report to the House of Delegates (HOD) at each Interim Meeting highlighting the year’s advocacy
5 activities and should include efforts, successes, challenges, and recommendations/actions to further
6 optimize advocacy efforts. The BOT has prepared the following report to provide an update on
7 2018 American Medical Association (AMA) advocacy activities.

8

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

18

19 DISCUSSION OF 2018 ADVOCACY EFFORTS

20

21 *Health system reform*

22

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

29

30 On June 7, 2018, the Department of Justice filed a brief declining to defend the Affordable Care
31 Act (ACA) in a case (*Texas v. United States*) brought by 20 state attorneys general. A week later,
32 the AMA and four physician specialty associations filed an amicus brief urging the court to reject
33 the effort to undermine the patient care gains under the ACA. In announcing the filing, the AMA
34 noted that “if the lawsuit were successful, federal policy could roll back to 2009, which would be
35 remarkably disruptive to our nation’s health system and every single American.” It would void
36 protections for those with pre-existing conditions, and provisions that allow children to remain on
37 their parents’ plan until age 26. Insurers would no longer be held to the 85 percent medical loss
38 ratio, meaning they could generate higher profits at the expense of coverage and payments for
39 services, and 100 percent coverage for certain preventive services would cease. Furthermore,

1 annual and life-time dollar limits could be reinstated, leading to more bankruptcies due to health
2 care costs.

3
4 Also in 2018, the Administration and the Congress attempted to continue chipping away at the
5 infrastructure of the ACA. The major “repeal and replace” efforts from 2017 were not repeated, but
6 there were several efforts to modify the ACA’s impact. The AMA commented extensively in the
7 regulatory process on the Administration’s actions—cutting back funds for navigators, shortening
8 the enrollment period, eliminating the cost sharing reduction subsidies, expanding association
9 health plans and short-duration limited coverage plans, and reducing risk adjustment payments.
10 The AMA is concerned that these actions will lead to higher cost/lower quality health plan choices
11 for many patients. The AMA is also opposing Medicaid work requirements that are being
12 considered by both federal and state policymakers.

13
14 *QPP implementation*

15
16 The AMA continues to support physicians as they transition to the Quality Payment Program
17 (QPP). The AMA is also working to improve the QPP at both the regulatory and legislative levels.
18 The Bipartisan Budget Act of 2018 included a number of QPP refinements requested by the AMA:

- 19
20 • Medicare Part B drug costs will be excluded from the Merit-based Incentive Payment System
21 (MIPS) payment adjustments and from the low-volume threshold determination;
22 • The Centers for Medicare & Medicaid Services (CMS) may reweight the MIPS cost
23 performance category to not less than 10 percent for the third, fourth and fifth program years
24 (rather than requiring a weight of 30 percent in the third year);
25 • CMS has more flexibility in setting the MIPS performance threshold for years three through
26 five to ensure a gradual and incremental transition to the threshold being set at the mean or
27 median performance level in the sixth year; and
28 • The Physician Focused Payment Model Technical Advisory Committee may provide initial
29 feedback regarding the extent to which alternative payment model proposals meet criteria and
30 an explanation of the basis for the feedback.

31
32 On July 12, CMS released a proposed rule covering Medicare physician fee schedule and QPP
33 changes for 2019. Positive elements of the proposal included:

- 34
35 • Reduced documentation burden for evaluation and management (E/M) office visit services;
36 • New payments for services that are not part of a face-to-face visit (e.g., virtual check-ins with
37 patients, remote patient consults using videos/photographs, online consults with other
38 physicians);
39 • Continuation of the low volume threshold policy to exempt practices from MIPS; and
40 • A reduction in problematic measures in the Promoting Interoperability component of MIPS
41 (formerly Meaningful Use and Advancing Care Information).

42
43 However, there were also several areas of concern for which the AMA will be recommending
44 changes in its comments to CMS, which are due on September 10. These include:

- 45
46 • A proposed collapse of E/M payments for physician office visit codes;
47 • Reduced payments for office visits and procedures performed on the same day; and
48 • The need for a simplified MIPS scoring framework and reduced quality measure requirements.

49
50 The AMA has been working with Federation groups to further identify positive and problematic
51 aspects of the proposed regulations, as well as potential constructive solutions.

Regulatory relief

The AMA is focused on regulatory relief and administrative simplification issues beyond what is included in the QPP. For example, in 2017 the AMA convinced CMS to retroactively align legacy pay-for-reporting programs with the current MIPS program for the 2016 reporting period, reducing penalties for physicians by \$22 million in 2018. This year, major regulatory wins include:

- The Veterans Administration agreed to exempt only employed physicians from multistate licensure requirements when delivering telehealth services;
- CMS created a new beneficiary look-up tool and launched an education campaign to assist physicians as beneficiaries' social security numbers are removed from their Medicare cards;
- CMS delayed implementation of appropriate-use criteria;
- Office of the National Coordinator promoted AMA STEPS Forward™ modules with the Federal Health IT Playbook;
- Medicare administrative contractors now must use targeted modeling for audits that emphasizes education to prevent billing errors before they are referred to recovery audit contractors (RACs);
- CMS auditors must use predictive analytics to focus audits on claims that are at high risk for improper payments; and
- RAC auditors now must reimburse physicians for medical records as part of the audit process.

The AMA also sponsored an online discussion board with practice managers and two focus groups with physicians in Chattanooga, TN, and Iselin, NJ, to further explore physicians' regulatory burdens in order to refine and prioritize its advocacy agenda. Topics covered during the discussions included electronic health record requirements, prior authorization, carrier audits, documentation burdens, prescription drug monitoring programs, and patient translators, among others.

The AMA also commented both to Congress and the Administration on the impact that current Stark self-referral and the anti-kickback statutes are having on physician development and adoption of alternative payment models.

Further, the AMA, through the Professional Satisfaction and Practice Sustainability focus area, has created a Debunking Regulatory Myths website to clarify common regulatory compliance questions for physicians as part of the broader effort to reduce administrative burdens.

Prior authorization (PA)

Prior Authorization (PA) has grown into a major concern among physicians due to patient care delays and practice burdens. The AMA conducted a survey of 1,000 practicing physicians at the end of 2017 which was released this year. Among surveyed physicians, 64 percent reported waiting at least one day for PA decisions from health plans, while 30 percent reported waiting at least three business days. Not surprisingly, 92 percent of physicians said that PA can delay access to necessary care. These delays may have serious implications for patients, as 78 percent of physicians reported that PA can lead to treatment abandonment, and 92 percent indicated that PA can have a negative impact on patient clinical outcomes. Moreover, PA hassles have been growing over time, with 86 percent of physicians reporting that PA burdens have increased over the past five years. Physicians and practice managers also placed PA at the top of their list of administrative frustrations in focus groups and online research conducted by the AMA.

To address these issues, the AMA has undertaken a major campaign to urge health plans to "right-size" PA programs. In January 2017, the AMA established a coalition of 16 other organizations and

1 released a set of 21 Prior Authorization and Utilization Management Reform Principles. Over 100
2 additional provider and patient groups have signed on to the principles as formal supporters. The
3 principles spurred conversations with health plans about the need for significant reform in PA
4 programs. One result of these discussions was the January 2018 release of the Consensus Statement
5 on Improving the Prior Authorization Process by the AMA, American Hospital Association,
6 America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield
7 Association, and Medical Group Management Association. This document reflects an agreement
8 between provider and health plan organizations to pursue PA reform in several key areas.

9
10 State legislative efforts are also critical in the AMA's campaign to improve PA processes, and the
11 AMA is working with state and specialty societies to enact PA and utilization management
12 legislation. The AMA offers model legislation that continues to serve as the basis for many of the
13 state bills and provides resources and support for these efforts. This year alone, more than 20 states
14 are addressing utilization management reform in their legislatures with significant enactments in
15 Indiana, New Mexico, and West Virginia. Physicians struggle with PA in the Medicare Advantage
16 (MA) and Medicare Part D drug plans, so the AMA is addressing PA issues at the federal level too.
17 These efforts include a recent AMA letter to CMS disputing the findings of a Government
18 Accountability Office report that recommended increased use of PA for Medicare-covered services.

19
20 The AMA has also launched a grassroots advocacy website dedicated to PA
21 (www.FixPriorAuth.org). The website includes both patient- and physician-oriented online
22 experiences that end with a "share your story" call to action. Compelling stories gathered thus far
23 are featured in the site's story gallery, and additional physician and patient PA accounts will be
24 added over time and used to guide and support the AMA's advocacy efforts. FixPriorAuth.org also
25 contains a resource library of PA-related news stories and AMA PA advocacy and educational
26 tools, including the three-part video series on electronic prior authorization that has been approved
27 for 0.25 credits of *AMA PRA Category 1 Credit*TM.

28 29 *Telemedicine*

30
31 After concerted AMA advocacy coupled with the efforts of the Digital Medicine Payment
32 Advisory Group (DMPAG), beginning January 1, 2018, Medicare expanded coverage of remote
33 patient chronic care management. This represents a historic expansion of coverage that extends
34 throughout the country without geographic limitations and includes services delivered virtually in a
35 patient's home. In addition, CMS has proposed to cover additional remote patient management
36 services including a range of technical and professional components that accurately reflect the costs
37 of delivering such services beginning January 1, 2019. Furthermore, the AMA's coalition building
38 and strong support for the Medicare telehealth provisions of the Bipartisan Budget Act of 2018
39 which passed earlier this year paves the way for expanded Medicare coverage for telestroke and
40 telehealth services for patients with end stage renal disease, chronically ill patients in Medicare
41 Advantage, as well as coverage of telehealth for beneficiaries in certain accountable care
42 organizations (two-sided risk models only).

43
44 The AMA has also worked at the state level to ensure coverage of telemedicine and modernization
45 of medical practice acts. In the 2018 legislative session, 44 states introduced over 160 telehealth-
46 related pieces of legislation. Many bills addressed different aspects of payment regarding both
47 private payers and Medicaid, with some bills making changes to existing payment laws. Many
48 states also proposed legislation directing licensure boards to establish standards for the practice of
49 telehealth within their given profession. The AMA was pleased to see that many of these bills were
50 either based on the AMA Telemedicine Act, or were amended to incorporate language from this
51 model bill. In addition, the AMA supported several state efforts to join the Interstate Medical

Licensure Compact, with now 24 states, DC, and Guam participating in the Compact's expedited licensure process.

Diabetes Prevention Program (DPP)

CMS approved coverage of the Medicare Diabetes Prevention Program (MDPP) effective April 2018. This was a very positive development in the effort to prevent diabetes on a national scale. To further advance these efforts, the AMA has been urging CMS to approve coverage of virtual or digital MDPP programs participation to improve access in rural and underserved areas. The AMA also has ongoing discussions with staff at the Center for Medicare & Medicaid Innovation (CMMI) about the MDPP and has been working to disseminate information about it to potential suppliers. For example, the AMA convened a webinar for health systems interested in the DPP with a CMMI presenter and developed a question-and-answer document for them following the webinar.

Mergers

The AMA was instrumental in last year's action to block the Anthem/Cigna and Aetna/Humana mergers. The Anthem/Cigna merger alone would have cost physicians \$500 million in payments annually. In 2018, the AMA had to evaluate several new potential mergers that were not just a health insurer merging with a health insurer but more complicated mergers such as CVS/Aetna which involves a health insurer merging with a pharmacy chain/pharmacy benefits manager (PBM).

In February, the AMA submitted a statement to the House Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law for a hearing on this merger. The statement expressed the AMA's concerns that the proposed merger has the potential to worsen competition (or reduce hopes for amelioration) in three poorly performing markets: PBM services; local health insurance markets; and many local retail pharmacy markets.

On June 19, the AMA moved to oppose the CVS/Aetna merger. This was announced in California at a Department of Insurance (DOI) hearing. AMA President Barbara L. McAneny, MD, presented testimony urging regulators to block the proposed CVS/Aetna merger because it is likely to substantially lessen competition in many health care markets, to the detriment of patients. A CVS/Aetna deal would allow the combined corporate entity to fortify dominant positions in health insurance, pharmaceutical benefit management, retail and specialty markets that already lack competition. The AMA's filing for the hearing also outlined further the merger's potential negative consequences for health care access, quality and affordability, including:

- An expected increase in premiums due to a substantial increase in market concentration in 30 of 34 Medicare Part D regional markets;
- An anticipated increase in drug spending and out-of-pocket costs for patients as Aetna and CVS fortify their dominant positions in the health insurance, pharmaceutical benefit management, retail and specialty pharmacy markets that already lack competition;
- Reduced competition in health insurance markets that will adversely affect patients with higher premiums and contribute to a decline in the quality of insurance; and
- A foreseeable failure to realize proposed efficiencies and benefits because the merger faces enormous implementation challenges, and those efficiencies have a questionable evidence base.

On August 1, 2018, the California DOI agreed with our arguments and those of the experts that testified, urging the U.S. Department of Justice (DOJ) to block the proposed merger. The AMA

1 also submitted extensive comments to the DOJ on the proposed merger on August 8. At the time of
2 this report, the outcome of the proposed merger had yet to be decided, so AMA advocacy
3 continues.

4 5 *Insurer coverage issues*

6
7 In 2018, the AMA continued to collaborate with state and specialty medical societies to ensure that
8 patients have appropriate coverage for unanticipated out-of-network care. The AMA continues to
9 promote coverage policies that are based on reasonable physician charges, to financially protect
10 patients and promote fair contracting between physicians and insurers. AMA model legislation
11 serves as the basis for many of these proactive efforts. Similarly, problematic state bills have been
12 regularly defeated as the AMA and medical societies communicate to legislators about their impact
13 on patient access to care and physician practice stability. The AMA has worked closely with state
14 medical associations and the American College of Emergency Physicians (ACEP) to combat
15 Anthem/BCBS policies that deny coverage for emergency care when the final diagnosis is
16 determined to be non-emergent. Legislative restrictions were adopted in Missouri.

17 18 *Modifier 25*

19
20 At the 2017 Interim Meeting, the House of Delegates established new policy to advocate against
21 payment reductions for evaluation and management (E/M) codes appropriately reported with a
22 Current Procedural Terminology (CPT) modifier 25. Considerable concerns regarding this issue
23 have been raised by many state medical associations and national medical specialty societies, most
24 recently in regard to health insurer Anthem's proposed policy to reduce payments by 50 percent for
25 E/M services billed with CPT modifier 25 when reported with a minor surgical procedure code
26 beginning in the first quarter of 2018. Several other insurers have followed suit with similar
27 proposals.

28
29 Starting in November 2017, the AMA advocated directly to Anthem to halt this proposed move.
30 The AMA sent a letter to Anthem expressing our concerns and hosted two meetings with AMA and
31 Anthem senior leadership. During these discussions, the AMA voiced strong objections to this
32 unwarranted reduction in physician payment and presented evidence showing that the
33 recommendations of the AMA/Specialty Society Relative Value Scale Update Committee (RUC)
34 do not include duplicative physician work or practice expense for procedures typically billed with
35 an E/M service on the same date. Many state medical associations and national medical specialty
36 societies also strongly advocated for Anthem to rescind this policy, which would impede the
37 provision of unscheduled, medically necessary care. Following these combined efforts, Anthem
38 withdrew its modifier 25 payment reduction. The AMA welcomed this news, as this policy would
39 have had resulted in a \$100 million cut in physician payments nationwide.

40
41 The AMA has continued advocacy on this issue, to include provision of supporting documentation
42 to assist medical societies in successfully fighting implementation of modifier 25 payment
43 reductions by Blue Cross Blue Shield of Michigan and Health Net in California. This will be an
44 ongoing campaign, and the AMA will engage national commercial insurers and governmental
45 entities considering similar policies involving modifier 25 or other CPT modifiers. The Centers for
46 Medicaid & Medicaid Services proposed a new application of the Modifier 25 policy as part of the
47 Evaluation and Management coding proposals. In comments on the proposed rule, the AMA
48 stressed that these reductions were inappropriate and if advanced would necessitate an extensive
49 review of related codes to assure that services were accurately valued.

Opioid epidemic

The opioid epidemic continues to have a devastating effect on our nation; however, there are signs of progress in physicians' actions to help end this public health epidemic. The AMA Opioid Task Force issued a report in June 2018 highlighting some of this progress:

- Between 2013 and 2017, the number of opioid prescriptions decreased by more than 55 million—or 22.2 percent;
- Use of prescription drug monitoring programs (PDMPs) is growing—more than 300 million queries were made in 2017;
- Naloxone prescriptions more than doubled in 2017, from approximately 3,500 to 8,000 dispensed per week;
- More than 549,000 physicians and other health care professionals completed continuing medical education (CME) trainings and other Federation education resources in 2017; and
- Finally, the number of physicians trained/certified to provide buprenorphine in-office continues to rise—more than 50,000 physicians are now certified—a 42 percent increase in the past 12 months.

Attention to the need for increased access to Medication Assisted Therapy (MAT) resources is a top priority in 2018—as is calling on health insurers to eliminate PA requirements and other barriers to MAT as well as enhancing access to comprehensive, multidisciplinary treatments for pain, including non-opioid alternatives. AMA model state legislation can help address these and other related areas.

At the federal level, Congress enacted the Consolidated Appropriations Act of 2018 which includes nearly \$4 billion for prevention, treatment, and law enforcement efforts targeted at addressing the opioid epidemic. The AMA has been calling for increased federal funding for several years.

In 2018, the AMA offered background, analysis, and technical support to at least 25 states as they addressed the opioid epidemic. This includes support for bills aligned with AMA policy, and efforts to amend or defeat bills with negative provisions. The AMA also continues to maintain and update the AMA opioid microsite, www.end-opioid-epidemic.org, with more than 400 education and training resources specific to state and specialty societies.

Pharmaceutical cost transparency

In 2018, the AMA is encouraging patients and physicians to share their stories about the impact of drug pricing and is urging state medical associations to advance AMA model legislation to increase transparency requirements on payers, pharmacy benefit managers and pharmaceutical manufacturers. The AMA also updated the Truthinrx.org website and continues to issue regular updates through the Patients Action Network (PAN) and the Physicians Grassroots Network (PGN) social media channels. The campaign is well-positioned to engage grassroots pressure in favor of positive reform-minded legislation once it materializes.

In May of 2018, the Trump Administration issued a Blueprint for addressing the problem, which is a high priority for the Secretary of HHS, Alex Azar. While the Blueprint lacks detail on key issues, it appears the focus will be on limited regulatory actions that the Administration can take without action by Congress.

The AMA commented on the Blueprint, and expressed strong support for a select number of provisions: (1) requiring pharmaceutical supply chain transparency; (2) accelerating and expanding

1 regulatory action to increase pharmaceutical market competition and combat anti-competitive
2 practices; (3) ensuring prescribers have accurate point-of-care coverage and patient cost-sharing
3 information as part of their workflow, including in the electronic health record (EHR); and
4 (4) ensuring federal programs and commercial practices billed as lowering prescription medication
5 prices do so for patients directly. The AMA identified and expressed concern about Blueprint
6 proposals that would increase patient costs and erect barriers, including onerous insurer paperwork
7 requirements that impede timely patient access to affordable and medically necessary medications
8 and treatments. Further, the AMA opposes policies that would financially penalize physicians and
9 pharmacists for high cost prescription medication.

10
11 The AMA also sent a letter of support to the Hill for S. 2554, which would prohibit the use of gag
12 clauses in a manner the AMA strongly supports and would provide the Federal Trade Commission
13 with clear authority to combat pay for delay agreements entered into between biological/biosimilar
14 companies.

15
16 The AMA has also been working to influence legislative efforts at the state level to address drug
17 costs, often by questioning the business practices and value equation that pharmacy benefit
18 managers (PBMs) add to the system. The AMA has been engaged in the development of model
19 bills by both the National Association of Insurance Commissioners (NAIC) and the National
20 Conference of Insurance Legislators (NCOIL) to better regulate PBM practices. Additionally,
21 nearly 20 states have now enacted legislation to allow pharmacists to discuss drug costs and
22 payment options with patients (gag clause legislation)—policies supported by the AMA and
23 outlined in AMA model legislation.

24 25 *Gun violence*

26
27 After another series of tragic mass shootings, the AMA renewed the call for the U.S. Centers for
28 Disease Control and Prevention (CDC) to investigate the root causes of gun violence. There is
29 concern that the CDC is prohibited from conducting this research, but the Dickey Amendment only
30 prohibits the CDC from using appropriated funds “to advocate or promote gun control.” The AMA
31 urged Congress to earmark appropriations specifically for gun violence research efforts. It also
32 commented on proposed regulations issued by the Department of Justice on so-called “bump
33 stocks.”

34
35 As the push for federal funding continues, the AMA recently partnered with the American
36 Foundation for Firearm Injury Reduction in Medicine (AFFIRM), a physician-led, non-profit
37 organization that aims to counter the lack of federal funding for gun violence research by
38 sponsoring gun violence research with privately-raised funds. AMA Trustee, Albert Osbahr, III,
39 MD, is on AFFIRM’s steering committee; other physician group partners include the American
40 College of Surgeons, American College of Emergency Physicians, and the Massachusetts Medical
41 Society. More information about the group can be found at www.affirmresearch.org.

42
43 In 2018, nine states (Kansas, Louisiana, Maryland, New York, Ohio, Oregon, Utah, Vermont and
44 Washington) enacted laws restricting access to firearms for individuals convicted of domestic
45 violence or subject to a restraining order due to domestic violence. Delaware, Florida, Illinois,
46 Maryland, Massachusetts, New Jersey, Rhode Island and Vermont passed laws establishing gun
47 violence restraining orders. Nine states (Connecticut, Delaware, Florida, Hawaii, Maryland, New
48 Jersey, Rhode Island, Vermont, and Washington) banned bump stocks. Finally, Florida, Louisiana,
49 New Jersey, Oregon, Tennessee and Vermont strengthened background check requirements.

The AMA adopted several policies on gun violence at its 2018 Annual Meeting and will continue to seek opportunities at the federal and state levels to advance new and existing AMA policy on this topic:

- Advocating for schools as gun-free zones;
- Calling for a ban on the sale of assault-type weapons, high-capacity magazines;
- Expanding domestic violence restraining orders to include dating partners;
- Removing firearms from high-risk individuals;
- Supporting an increase in legal age of purchasing ammunition and firearms from 18 to 21;
- Opposing federal legislation permitting “concealed carry reciprocity” across state lines; and
- Supporting gun buyback programs in order to reduce the number of circulating, unwanted firearms.

Scope of Practice

Policy adopted at the 2017 Interim Meeting called on the AMA to convene a meeting of relevant physician stakeholders to create a consistent national strategy to effectively oppose efforts to grant independent practice to non-physician practitioners. To implement this directive, the AMA hosted a summit at AMA headquarters in March 2018. The Scope of Practice Partnership (SOPP) provided funding to support the summit. Eighty-one physicians, executive staff, and government affairs staff from 32 state medical associations, 16 national medical specialty societies, and the American Osteopathic Association joined AMA leadership and staff at the summit. The strategy resulting from this meeting was discussed in detail at the A-18 SOPP meeting and will guide our ongoing advocacy efforts.

In 2018, there was a great deal of concern about the Advanced Practice Registered Nurse (APRN) Compact, a multistate licensure compact developed by the National Council of State Boards of Nursing (NCSBN). It establishes a process by which an APRN with certain credentials can receive a multistate license that allows the APRN to practice in any APRN Compact member state. APRNs practicing under this multistate license can practice and prescribe independently, despite any state law to the contrary. Idaho, North Dakota, and Wyoming have joined the APRN Compact, which will go into effect if 10 states join. Due to AMA and Federation efforts, bills were defeated in Iowa, Minnesota, Nebraska, and no further APRN Compact bills were enacted in 2018.

Immigration

Based on policy adopted at A-18, the AMA wrote to the Administration to withdraw its “zero tolerance” immigration policy and to stop separating children from their families. The fear is that Administration’s policy will do great harm to children and their parents or caregivers. The AMA sent the letter to the secretaries of the Homeland Security and Health and Human Services departments, as well as the U.S. Attorney General. The letter pointed out that childhood trauma and adverse childhood experiences created by inhumane treatment often create negative health impacts that can last an individual’s entire lifespan. The president subsequently issued an executive order reversing the Administration’s position on separating children. The AMA is closely monitoring the reunification of parents and children.

The AMA also voiced concerns in a letter to the Director of the U.S. Citizenship and Immigration Services about delays in H-1B visa processing due to increased inspection of prevailing wage data for incoming non-U.S. international medical graduates (IMGs) who have accepted positions in U.S. Graduate Medical Education (GME) programs.

Cybersecurity

The AMA has been raising awareness of cybersecurity threats to physician practices. Last year, an AMA/Accenture survey of 1300 physicians found that phishing and viruses are the most common types of cyberattacks encountered by small practices. Viruses often appear as a result of software that is not regularly updated or “patched.” To assist physicians, the HHS Office for Civil Rights (OCR) issued a monthly newsletter devoted to cybersecurity issues. In addition to encouraging the federal government to issue additional guidance like this to physicians, the AMA continues to urge stakeholders—including health information technology vendors—to pay special attention to the needs of small and mid-sized practices, which often lack the resources that larger practices and health systems enjoy.

Protecting the patient-physician relationship

In response to the Administration’s plan to withhold federal family planning funding from Planned Parenthood and other entities, the AMA issued a statement and submitted comments strongly objecting to the policy change, asserting that it interferes with patient-physician relationships and negatively affects quality of care. The HHS announcement specifically noted that the regulation update “would prohibit referral for abortion as a method of family planning.” The proposal would also endanger access to care that the Title X program has helped to facilitate. Title X has helped to expand access to basic reproductive health care like birth control, cancer screenings, STI testing and treatment, and exams. The program serves roughly 4 million people every year, many of whom would otherwise be unable to access care. The AMA’s stance on this issue is in keeping with its longstanding position on maintaining patient choice and physician freedom to practice in the setting they choose, and reflects a broader commitment to protecting free communication between patients and physicians.

Physician conscience rights

In 2018, HHS issued a Notice of Proposed Rulemaking on “Protecting Statutory Conscience Rights in Health Care; Delegations of Authority.” In response, the AMA sent a letter to Secretary Azar to express opposition to the measure, citing concern for vulnerable patient populations and asserting that conscience rights for physicians are not unlimited. The proposed rule would dramatically expand the discretion that religious or moral objectors have to refuse care without meaningful safeguards to ensure that the rights of those receiving care are protected. The rule is part of a broader Administration effort to protect religious rights and follows the announcement in late January of the creation of a new office within the Office of Civil Rights (OCR), the Conscience and Religious Freedom Division. The AMA is alarmed because if implemented, the rule would function as a shield for people asserting objections on religious or moral grounds and could permit them to withhold care from already vulnerable groups and create confusion in health care institutions. While the AMA is committed to conscience protections for physicians and other health professional personnel, the exercise of those rights must be balanced against the fundamental obligations of the medical profession and physicians’ paramount responsibility and commitment to serving the needs of their patients.

Equality issues

Five states (Delaware, Hawaii, Maryland, New Hampshire, and Washington) enacted laws opposing “conversion therapy.” AMA policy strongly opposes conversion therapy, and the AMA stands ready to work with state medical associations interested in pursuing a ban on this harmful practice.

1 In addition, the AMA advocated before the U.S. Department of Veterans Affairs and the
2 Department of Defense on coverage for transgender-related health care services.

3
4 *Tobacco*

5
6 The AMA along with more than a dozen other physician groups sent a letter to ranking members of
7 the Senate and House appropriations committees urging them to oppose any provisions that weaken
8 or delay the U.S. Food and Drug Administration's (FDA) ability to regulate any and all tobacco
9 products. Responding to provisions passed by the House in recent years that exempt thousands of
10 tobacco products—including many candy- and fruit-flavored products now favored by teens—from
11 the scientific review process mandated by the Family Smoking and Prevention Tobacco Control
12 Act is cause for concern as 11.3 percent of high school students in 2016 reported using e-cigarettes
13 during the last 30 days. Under these House provisions, many tobacco products that the FDA had
14 only just begun to regulate, such as e-cigarettes and cigars, would be exempted from a product
15 review if they were on the market prior to Aug. 8, 2016. The oft-cited reason for these provisions is
16 the ability of e-cigarettes to help smokers quit traditional cigarettes; however, the efficacy of this is
17 not yet proven by the research.

18
19 At the state level, Maine and Oregon raised the tobacco purchase age to 21. Five states now have
20 this requirement. California, Hawaii, and New Jersey enacted laws in previous sessions.

21
22 *Economic Impact Study*

23
24 At the beginning of 2018, the AMA released its updated Economic Impact Study. The report gives
25 policymakers concrete evidence demonstrating how their local communities tangibly benefit when
26 they support legislation that helps physician practices thrive. The 2018 study found that nationally:

- 27
28 • Physicians support nearly 12.6 million jobs. On average, each physician supports more than 17
29 jobs;
30 • Physicians create a total of \$2.3 trillion in economic output, comprising about 13 percent of the
31 total U.S. economy. On average, each physician supports \$3.2 million in economic output;
32 • Physicians contribute more than \$1 trillion in wages and benefits for all supported jobs. On
33 average, physicians support \$1.4 million in total wages and benefits per physician; and
34 • Physicians support \$92.9 billion in state and local tax revenues—approximately \$126 thousand
35 per physician on average.

36
37 *AMPAC Activities*

38
39 AMPAC has once again worked closely with its state medical association PAC partners this
40 election cycle on contribution support decisions for candidates running Congress. A report
41 summarizing AMPAC activities will be distributed at the Interim Meeting in National Harbor.

42
43 **CONCLUSION**

44
45 Once again, the AMA has delivered some significant advocacy victories in a challenging political
46 environment. The outcome of the 2018 elections is unknown at the time this report was prepared,
47 but the AMA is poised to work with both sides of the aisle in 2019 to advance the interests of
48 patients and physicians on the most critical health care issues. The AMA thanks its Federation
49 partners for their collaboration and support and looks forward to tackling medicine's biggest issues
50 when newly elected state and federal officials take office in January.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 6-I-18

Subject: Update on TruthinRx Grassroots Campaign

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

1 INTRODUCTION

2
3 At the 2017 Interim Meeting, the House of Delegates adopted Policy D-110.988[2] “Prescription
4 Drug Price and Cost Transparency,” which asked for a report back to the House of Delegates at the
5 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign. This
6 report, which is presented for the information of the House, summarizes the creation of the
7 TruthinRx grassroots campaign, its evolution, and its progress and impact. The report also
8 summarizes relevant American Medical Association (AMA) policy and advocacy, which is
9 reflected in the TruthinRx grassroots campaign.

11 BACKGROUND

12
13 In 2015, Policy H-110.987, “Pharmaceutical Costs,” directed the AMA to convene a task force of
14 appropriate AMA Councils, state medical societies, and national medical specialty societies to
15 develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical
16 costs and improving patient access and adherence to medically necessary prescription drug
17 regimens. Accordingly, the AMA convened a Task Force on Pharmaceutical Costs, which met four
18 times in the first six months of 2016 to develop principles to guide advocacy and grassroots efforts
19 aimed at addressing pharmaceutical costs. The Task Force agreed that increasing transparency
20 among pharmaceutical companies, health plans, and pharmacy benefit managers (PBMs) should be
21 the initial focus of the campaign, which led to the launch of a grassroots campaign in the third
22 quarter of 2016, and the launch of the TruthinRx website, *TruthinRx.org*, on November 1, 2016.

24 EVOLUTION OF THE TRUTHINRX GRASSROOTS CAMPAIGN

25
26 The goal of the TruthinRx campaign has been to mobilize the AMA Physician Grassroots Network
27 (PGN), the AMA Patient Action Network (PAN), the public, and thought leaders around the
28 challenges posed by the lack of transparency surrounding prescription drug pricing and costs.
29 *TruthinRx.org* engages physicians, patients/consumers, and health care policy influencers by:
30 (a) providing critical information about prescription drug price and cost challenges, as well as the
31 lack of drug price and cost transparency, and (b) facilitating grassroots action in support of
32 improving prescription drug price and cost transparency. Since its launch in November 2016,
33 *TruthinRx.org* has evolved through two key stages. In its first stage, the *TruthinRx.org* landing
34 page focused on informing visitors about how drug price negotiations happen behind closed doors
35 and how pharmaceutical companies, PBMs, and health insurance companies participate in these
36 negotiations. The page concludes that “when patients are left out, health care suffers.” This landing
37 page directs visitors to four main website subsections:

- 38
39 • “Your Stories” – invites visitors to read and contribute their own stories about how the lack of
40 transparency in drug pricing impacts our health care system.

- 1 • “Behind the Label” – illustrates how the lack of transparency in prescription drug pricing and
2 costs – involving opaque price agreements between PBMs, health plans, and pharmaceutical
3 manufacturers – contributes to adverse patient effects such as increased costs and unpredictable
4 price swings for patients, and ultimately adversely affects patients and physicians.
- 5 • “Get Involved” – facilitates grassroots advocacy by providing visitors with a customizable
6 message that can be personalized to US Senators and Representatives, calling on legislators to
7 support increased transparency in prescription drug prices. Additionally, visitors have an
8 opportunity to subscribe to future legislative updates and alerts from the AMA.
- 9 • “Get Informed” – provides visitors with a myriad of timely articles to help them understand the
10 seemingly arbitrary costs of prescription medication. The articles are categorized according to
11 the following thought-provoking questions:
 - 12 o “What influences the price of drugs?”
 - 13 o “How does drug pricing affect patients like you?”
 - 14 o “What’s being done to help?”

15
16 At the time that this report was written, the second stage of *TruthinRx.org* was scheduled to be
17 launched in fall of 2018 to further mobilize voters around the issue of prescription drug price
18 transparency. *TruthinRx.org* will include an interactive data visualization that highlights various
19 reasons why drug prices fluctuate. The data visualization will explore the roles of four key themes
20 behind drug price fluctuation: (1) generics – despite the assumption that generic drugs will be
21 affordable, over time, the prices of generic drugs can rise significantly; (2) competition – despite
22 the expectation that competition in the marketplace would lead to lower prices, competitors’ prices
23 can seemingly increase simultaneously; (3) acquisition – the price of drugs produced by a given
24 company can rise significantly after the company is acquired; and (4) supply chain dynamics –
25 PBMs cast themselves as saving money, but with the lack of supply chain transparency, it is
26 unclear how these middlemen negotiate drug prices. The data visualization will lead to a call to
27 action for improved transparency. This interactive subsection of *TruthinRx.org* can be used both on
28 mobile and desktop devices, and is designed so that it can be shared on social media.

30 PROGRESS AND IMPACT OF THE TRUTHINRX GRASSROOTS CAMPAIGN

31
32 The TruthinRx grassroots campaign has significantly impacted public awareness of, and grassroots
33 action in response to, the opaque process that pharmaceutical companies, PBMs, and health plans
34 engage in when pricing prescription drugs. Between the website’s launch in November 2016 and
35 August 2018, the TruthinRx campaign has achieved the following milestones:

- 37 • The TruthinRx campaign generated 827,759 messages sent to Congress demanding price
38 transparency.
- 39 • As part of the TruthinRx grassroots campaign, the PAN launched a petition calling for
40 increased prescription drug price and cost transparency, and this petition has been signed by
41 275,590 individuals.
- 42 • *TruthinRx.org* has been visited 117,474 times, by 95,873 unique internet users.
- 43 • The AMA has published 656 posts on Twitter and Facebook focused on the TruthinRx
44 campaign. Combined, these posts were displayed 10,859,853 times (“impressions”). This led to
45 514,118 people interacting with the posts (“engagements”).
- 46 • Evidencing the TruthinRx campaign’s continued impact on public discussion, since July 2017,
47 the hashtag “#TruthinRx” has been mentioned on Twitter and/or Facebook 1,617 times.

1 AMA POLICY AND ACTIVITY

2
3 It is important to recognize that the TruthinRx grassroots campaign is one key component of a
4 much broader, ongoing AMA focus on prescription drug affordability. Recent AMA policy and
5 activity aimed at improving prescription drug price and cost transparency include:
6

- 7 • The AMA developed and disseminated model state legislation entitled, “An Act to Increase
8 Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases during the
9 Plan Year.”
- 10 • The AMA submitted comments in July 2018 in response to the HHS Blueprint to Lower Drug
11 Prices and Reduce Out-of-Pocket Costs. Patient and other stakeholder experiences with
12 affordability and lack of access that were obtained through the TruthinRx campaign were
13 incorporated as vignettes in this comment letter. The AMA has received positive feedback on
14 these vignettes.
- 15 • In April 2018, Jack Resneck, Jr., MD, testified at the US House of Representatives Democratic
16 Steering and Policy Committee Briefing on Prescription Medication Pricing and Access
17 Challenges and Solutions. Dr. Resneck’s testimony focused on how the lack of prescription
18 drug pricing transparency impacts his patients.
- 19 • In December 2017, Gerald e. Harmon, MD, testified before the Health Subcommittee of the US
20 House of Representatives Committee on Energy and Commerce on the topic of “Examining the
21 Pharmaceutical Supply Chain.” Dr. Harmon’s testimony focused on what the escalating cost
22 and complexity of obtaining medically necessary prescriptions or physician-administered drug
23 treatments mean for patient adherence, timely access, and health outcomes.
- 24 • Policy H-110.987, which encourages prescription drug price and cost transparency among
25 pharmaceutical companies, PBMs, and health insurance companies and establishes extensive
26 AMA policy aimed at improving access to affordable prescription drugs, including: promoting
27 legislation that authorizes the Attorney General and/or the Federal Trade Commission (FTC) to
28 take legal action to address price gouging by pharmaceutical manufacturers and increase access
29 to affordable drugs for patients, and encouraging FTC actions to limit anticompetitive behavior
30 by pharmaceutical companies attempting to reduce competition from generic manufacturers.
- 31 • Policy H-110.987, also directs the AMA to provide assistance upon request to state medical
32 associations in support of state legislative and regulatory efforts addressing drug price and cost
33 transparency.
- 34 • Policy H-125.979, which supports legislation or regulation that secures private health insurance
35 formulary transparency.
- 36 • Policy H-110.991, which advocates for greater prescription drug price transparency at the
37 pharmacy point-of-sale.
- 38 • Policy H-110.991, also supports physician education regarding drug price and cost
39 transparency and challenges patients may encounter at the pharmacy point-of-sale.

40
41 Moreover, the AMA is continuing to develop evolving policy in support of improved prescription
42 drug affordability. Ongoing AMA initiatives include:
43

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

1 CONCLUSION

2
3 In the approximately two years since the TruthinRx grassroots campaign was launched, the
4 initiative has demonstrated significant success in engaging physicians, patients/consumers, and
5 health care policy influencers in discussion of and advocacy to improve prescription drug price and
6 cost transparency. As described above, the TruthinRx campaign is a key component of a broader,
7 ongoing AMA focus on prescription drug affordability, and *TruthinRx.org* will continue to evolve
8 as relevant AMA policy evolves. The objective metrics outlined above indicate that the TruthinRx
9 grassroots campaign is succeeding in stimulating public discourse, and *TruthinRx.org* will continue
10 to be updated to capture public attention and mobilize action.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-I-18

Subject: 2019 Strategic Plan

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

Our AMA continues to execute its multi-year strategy to achieve significant positive impact for physicians, medical students, and patients. The strategy, launched in 2013, identified three areas of emphasis in our mission areas: Improving Health Outcomes, Accelerating Change in Medical Education, and Shaping Care Delivery and Payment for Professional Satisfaction and Practice Sustainability. These areas have evolved to more encompassing strategic arcs: 1) improving the health of the nation by confronting the chronic disease burden, 2) reimagining medical education, training, and lifelong learning, and 3) attacking the dysfunction in health care by removing the obstacles and burdens that interfere with patient care. They provide for tangible and meaningful implementation of our AMA's mission to promote the art and science of medicine and the betterment of public health.

Through this report, the Board of Trustees affirms AMA's multi-year strategic focus. This report is devoted to what is on the horizon for each of these areas in 2019 and highlights other work to modernize the means through which physicians can engage in advancement of the mission.

ATTACKING THE DYSFUNCTION IN HEALTH CARE

With the continued dramatic shifts in the health care landscape putting more pressure on physicians and their practices, our work continues to focus on addressing the organizational and system level dysfunction that hinders physicians' ability to provide high quality patient care. Through our ongoing work, we are committed to making the patient-physician relationship more valued than paperwork, technology an asset and not a burden, and physician burnout a thing of the past. The goal is to create a future pathway for physicians to choose from a broad array of payment and health care delivery models, including viable fee-for-service options, which can provide a sustainable and satisfying physician practice. We are focused on improving—and setting a positive future path for—the operational, financial and technological aspects of a physician's practice.

Successful navigation and implementation of evolving public and private payment systems requires heightened physician awareness, informed assessment of options, and, potentially, new strategic and operating methods to optimize success. To support physicians through this changing landscape and improve care delivery and professional satisfaction, AMA will work in 2019 to:

- Advocate for legislative and regulatory changes that enhance prospects for physicians to succeed.
- Generate awareness and encourage physicians to prepare for evolving payment model changes.
- Provide multi-modal, multi-channel physician education about what new payment model options mean for physicians and patients.

- Guide physicians toward the best outcome in value-based care systems and establish the AMA as a valued source of support on issues spanning a wide range of care delivery and payment models.
- Expand the resources delivered through the STEPS Forward: Practice Improvement Strategies program and other tools to help physicians in a variety of practice settings learn new techniques to improve practice workflow, patient care and professional satisfaction.
- Increase the awareness and importance of professional satisfaction and support the Quadruple Aim through additional research, partnerships, and resources to assist physicians throughout the various settings and stages of their careers.
- Build on the foundation of prior years' work in the area of physician burnout and professional satisfaction by expanding our empirical research in and understanding of the organizational, system, and environmental factors that contribute to burnout with the aim of developing efficacious methods to defeat the problem at its source.
- Discover and promote the physician perspective across health technology sectors, directing development for improved usability, productive access to data, and respect for the patient-physician relationship.

In addition based on new AMA policy (Policy H-480.940, "Augmented Intelligence in Health Care") passed at A-18 we will build on our research and development capacity to further our understanding of how best to incorporate the emerging field of artificial intelligence into medical practice to preserve and enhance the patient physician relationship.

IMPROVING THE HEALTH OF THE NATION

Initiatives focused on health outcomes, particularly in the area of prevention and management of chronic care, underscore AMA's foundational commitment to improving the health of the nation. Concentrating on risk factors for cardiovascular disease and type 2 diabetes, our AMA is working with physicians and care teams to bring new approaches for anticipating, preventing, and managing widely prevalent chronic conditions. We have fixed on two ambitious long term goals:

- To have a nation where there is no incidence of preventable type 2 diabetes.
- To have a nation where all adults are meeting their blood pressure goals.

To achieve the scale required for this ambitious set of programs, AMA has developed multi-year strategic relationships with the Centers for Disease Control and Prevention (CDC) and the American Heart Association (AHA), whose national reach and influence reinforce and complement AMA resources. Our shared goals with the CDC and the AHA include significantly increasing the number of physician practices, health care systems and federally qualified health centers that:

- Screen patients for prediabetes and refer eligible patients to CDC-recognized diabetes prevention programs (DPPs) as the preferred option for preventing type 2 diabetes; and
- Improve care for patients with hypertension to achieve and sustain 70 percent or higher blood pressure control rates within the communities they serve.

AMA's partnerships with the CDC and AHA are solid and we are complementing them with collaborations with medical societies, business groups, payers, technology companies, and medical schools (through the ACE consortium) to offer evidence-based products, tools and services to support physicians, care teams, health system leaders and medical students in achieving the health outcomes we seek. Materials have been developed and distributed for use in practice settings ranging from small private practices to large integrated systems. The material and programs have been empirically demonstrated to be effective and our main focus is to create the environmental,

1 distribution, and awareness elements conducive to wide spread scaling. In this regard, we continue
2 to define and promote the “business case” for public and private payer coverage of proven
3 interventions such as diabetes prevention programs (for which Medicare began coverage in 2018)
4 and self-measured blood pressure monitoring devices. Looking forward in 2019, we intend to
5 blend the “best of” our prediabetes and hypertension work and add programming on cholesterol
6 management to assist physicians and care teams more comprehensively with cardiovascular risk
7 reduction for their patients.

8 9 REIMAGINE MEDICAL EDUCATION, TRAINING, AND LIFE LONG LEARNING

10
11 We are committed to a comprehensive approach to physician professional education and learning.
12 In 2019, the AMA will have mature and substantial effort in undergraduate medical education, be
13 expanding to graduate medical education and have a growing presence in physician lifelong
14 learning. These programs are designed to respond to the on the ground needs of physicians in the
15 evolving environment in which practice by utilizing modern adult education knowledge and digital
16 technology.

17
18 Since 2013 the AMA has supported a Consortium of medical schools, now 32 in number, to
19 accelerate change in medical education by creating a system that trains physicians to meet the
20 needs of today's patients and to anticipate future changes. Facilitated by the AMA through
21 individual and collaborative work the consortium schools have created new and innovative
22 programs and technologies that are increasingly adopted by medical schools throughout the nation.
23 Of particular note are the consortium’s health system science textbook that is being adopted by
24 more and more medical schools and the successful application of the chronic care curriculum based
25 on work done in our Improving Health Outcomes area. The latter is an example of the application
26 of work emanating from one strategic area to another critical arena.

27
28 The initial grant period of the Consortium ends in 2018, but due to the success of this collaboration
29 the schools have committed to continue to work together with AMA programmatic support to
30 sustain and grow this community of innovation, but without further grant funds. This is an example
31 of our efforts to cost effectively catalyze change through partnerships and collaborations. In 2019,
32 based on the experience and learning from the work in undergraduate medical education, we will
33 initiate a multi-year program to smooth the transition from medical school to residency through a
34 number of demonstration programs that include medical schools, residency programs, and
35 associated health systems.

36
37 In 2018, we continued to build education delivery capabilities with the development and launch of
38 the new AMA Ed Hub™ platform. The platform blends innovations in content, technology, and
39 user experience to deliver increasingly more personalized and compelling virtual learning
40 experiences to meet individual needs and preferences. AMA Ed Hub brings together the AMA’s
41 diverse educational offerings under one unified umbrella. Included are Learning™, STEPS
42 Forward™, GME Competency Education Program (GCEP), e-learning modules that support the
43 AMA’s Health Systems Science textbook, interactive micro-learning modules based on the AMA’s
44 modernized Code of Medical Ethics, curricula related to pain management, firearm safety and other
45 topics. As we look to 2019 and beyond, we will continue to build and enhance the platform as a set
46 of digital solutions that optimizes discovery of educational content for individual users, facilitates
47 delivery of an educational curriculum at an organization level, explores innovations in learning
48 experiences more closely connected to physicians’ daily practice, and expands automatic reporting
49 capabilities to support licensure and certification. We also will be exploring collaborations with
50 other organizations to advance both educational content and platform offerings.

1 ENGAGING PHYSICIANS AND ADVANCING THE MISSION

2
3 Our ambitions are high and we must utilize all available tools and assets to reach them. To this end
4 we wish to highlight three areas of leverage.

5
6 First, beginning in 2016 we have been building an innovation ecosystem that connects AMA
7 experience, knowledge, and mission priorities with technology and private sector groups. Our
8 wholly owned Silicon Valley situated subsidiary Health 2047 is a centerpiece of this effort.
9 Accessing world class technology, product development, and venture expertise it focuses on the
10 commercial complements of the AMA's strategic arcs. It has already founded a data
11 interoperability company and we anticipate several new ventures in 2019 that will address other
12 important areas that advance our mission.

13
14 Second, the goal of health equity is infused in all our strategic work. Each of the mission areas
15 have components directed toward the health equity goal. Based on guidance from the House and
16 with the support of the Board of Trustees in 2019 AMA management will establish a functional
17 hub that further facilitates and enhances concentration on this area. The unit's objective will be to
18 ensure optimal coordination, collaboration, and program development across the AMA's mission
19 areas in support of our commitment to national health equity.

20
21 Third, as evidence of AMA mission impact continues to grow, there is an opportunity for AMA to
22 deepen its engagement and strengthen its brand identity among physicians, students, residents and
23 other stakeholders. By leveraging more sophisticated approaches to identifying interests and needs
24 of the physician population, we can continuously improve our services and offerings to retain and
25 grow our membership base. We will create new connections, drive awareness and increase
26 opportunities to interact with the AMA using traditional and interactive/social/digital media,
27 building off our experience in 2018.

28
29 The momentum that supports this multi-year strategy is a reflection of collaboration and shared
30 commitment across the AMA and the Federation of medicine, academic institutions, public and
31 private health sector organizations, technology innovators, physicians, and physicians in training.
32 Together we will chart a course for health care delivery that will improve the health of the nation.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 1-I-18

Subject: Medical Tourism

Presented by: James E. Sabin, MD, Chair

1 INTRODUCTION

2
3 At the 2018 Annual meeting, the American Medical Association (AMA) House of Delegates
4 adopted the recommendations of Council on Ethical and Judicial Affairs Report 3-A-18, “Medical
5 Tourism.” The Council issues this Opinion, which will appear in the next version of AMA
6 PolicyFinder and the next print edition of the *Code of Medical Ethics*.
7

8 E-1.2.13 – Medical Tourism

9
10 Medical tourists travel to address what they deem to be unmet personal medical needs,
11 prompted by issues of cost, timely access to services, higher quality of care or perceived
12 superior services, or to access services that are not available in their country of residence. In
13 many instances, patients travel on their own initiative, with or without consulting their
14 physician, and with or without utilizing the services of commercial medical tourism companies.
15 The care medical tourists seek may be elective procedures, medically necessary standard care,
16 or care that is unapproved or legally or ethically prohibited in their home system.
17

18 Many medical tourists receive excellent care, but issues of safety and quality can loom large.
19 Substandard surgical care, poor infection control, inadequate screening of blood products, and
20 falsified or outdated medications in lower income settings of care can pose greater risks than
21 patients would face at home. Medical tourists also face heightened travel-related risks. Patients
22 who develop complications may need extensive follow-up care when they return home. They
23 may pose public health risks to their home communities as well.
24

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

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

Physicians need to be aware of the implications of medical tourism for individual patients and the community.

Collectively, through their specialty societies and other professional organizations, physicians should:

- (a) Support collection of and access to outcomes data from medical tourists to enhance informed decision making.
- (b) Advocate for education for health care professionals about medical tourism.
- (c) Advocate for appropriate oversight of medical tourism and companies that facilitate it to protect patient safety and promote high quality care.
- (d) Advocate against policies that would require patients to accept care abroad as a condition of access to needed services.

Individually, physicians should:

- (e) Be alert to indications that a patient may be contemplating seeking care abroad and explore with the patient the individual's concerns and wishes about care.
- (f) Seek to familiarize themselves with issues in medical tourism to enable them to support informed decision making when patients approach them about getting care abroad.
- (g) Help patients understand the special nature of risk and limited likelihood of benefit when they desire an unapproved therapy. Physicians should help patients frame realistic goals for care and encourage a plan of care based on scientifically recognized interventions.
- (h) Advise patients who inform them in advance of a decision to seek care abroad whether the physician is or is not willing to provide follow-up care for the procedure(s), and refer the patient to other options for care.
- (i) Offer their best professional guidance about a patient's decision to become a medical tourist, just as they would any other decision about care. This includes being candid when they deem a decision to obtain specific care abroad not to be in the patient's best interests. Physicians should encourage patients who seek unapproved therapy to enroll in an appropriate clinical trial.
- (j) Physicians should respond compassionately when a patient who has undergone treatment abroad without the physician's prior knowledge seeks nonemergent follow-up care. Those who are reluctant to provide such care should carefully consider:
 - (i) the nature and duration of the patient-physician relationship;
 - (ii) the likely impact on the individual patient's well-being;
 - (iii) the burden declining to provide follow-up care may impose on fellow professionals;
 - (iv) the likely impact on the health and resources of the community.

Physicians who are unable or unwilling to provide care in these circumstances have a responsibility to refer the patient to appropriate services. (IV, V, VI)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS^{1*}

CEJA Opinion 2-I-18

Subject: Expanded Access to Investigational Therapies

Presented by: James E. Sabin, MD, Chair

INTRODUCTION

At the 2018 Annual meeting, the American Medical Association (AMA) House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 4-A-18, “Expanded Access to Investigational Therapies.” The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-7.3.10 – Expanded Access to Investigational Therapies

Physicians who care for patients with serious, life-threatening illness for whom standard therapies have failed, are unlikely to be effective, or do not exist should determine whether questions about access to investigational therapy through the U.S. Food and Drug Administration’s “expanded access” program are likely to arise in their clinical practice. If so, physicians should familiarize themselves with the program to be better able to engage in shared decision making with patients.

When a patient requests expanded access to an investigational therapy, physicians should:

- (a) Assess the patient’s individual clinical situation to determine whether an investigational therapy would be appropriate, including:
 - (i) whether there is a satisfactory alternative therapy available to diagnose, monitor, or treat the patient’s disease or condition;
 - (ii) the nature of potential risks of the investigational therapy and whether those risks are not unreasonable in the context of the patient’s disease or condition;
 - (iii) whether the potential benefit to the patient justifies the risks of the investigational therapy;
 - (iv) whether the patient meets inclusion criteria for an existing clinical trial of the investigational therapy.

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1 (b) As part of the informed consent process, advise the patient (or parent/guardian if the
2 patient is a minor) that the investigational therapy has not yet been demonstrated to be
3 effective in treating the patient's condition and may pose as yet unknown risks.
4 Physicians should explain the importance of clinical trials, encourage patients who meet
5 inclusion criteria to participate in an existing trial rather than seek access to
6 investigational therapy through the FDA expanded access program, and direct patients
7 who wish to participate in research to appropriate resources.
8

9 (c) Decline to support an application for expanded access to an investigational therapy
10 when:
11

- 12 (i) the physician judges the treatment with the investigational therapy not to be in the
13 patient's best interest, and explain why; or
14
15 (ii) the physician does not have appropriate resources and ability to safely supervise
16 the patient's care under expanded access.
17

18 In such cases, physicians should refer the patient to another physician with whom to discuss
19 possible application for expanded access.
20

21 (d) Discuss the implications of expanded access for the patient and family and help them
22 form realistic expectations about what it will mean to be treated with the investigational
23 therapy outside a clinical trial. Physicians should alert patients:
24

- 25 (i) to the possibility of financial or other responsibilities associated with receiving an
26 investigational therapy through expanded access;
27
28 (ii) to the lack of infrastructure to systematically monitor and evaluate the effects of
29 the investigational therapy outside a clinical trial;
30
31 (iii) that they need information about how to contact the manufacturer for guidance if
32 they seek emergency care from a health care professional who is not affiliated with
33 a clinical trial of the investigational therapy;
34
35 (iv) that the physician has a responsibility to collect and share clinical information
36 about the patient's course of treatment with the investigational therapy, as well as
37 to report any adverse events that may occur over the course of treatment;
38
39 (v) to the conditions under which the physician would recommend stopping treatment
40 with the investigational therapy. (V,VI)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 3-I-18

Subject: Mergers of Secular and Religiously Affiliated Health Care Institutions

Presented by: James E. Sabin, MD, Chair

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 2-A-18, “Mergers of Secular and Religiously Affiliated Health Care Institutions.” 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 – 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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1 (c) Negotiate contractual issues of governance, management, financing, and personnel that
2 will respect the diversity of values within the community and at minimum that the same
3 breadth of services and care remain available to the community.

4
5 (d) Recognize that physicians' primary obligation is to their patients. Physician-leaders in
6 consolidated health systems should provide avenues for meaningful appeal and advocacy
7 to enable associated physicians to respond to the unique needs of individual patients.

8
9 (e) Establish mechanisms to monitor the effect of new institutional arrangements on patient
10 care and well-being and the opportunity of participating clinicians to uphold professional
11 norms, both to identify and address adverse consequences and to identify and disseminate
12 positive outcomes.

13
14 Individual physicians associated with secular and faith-based institutions that have or propose
15 to consolidate should:

16
17 (f) Work to hold leaders accountable to meeting conditions for professionalism within the
18 institution.

19
20 (g) Advocate for solutions when there is ongoing disagreement about services or arrangements
21 for care. (VII, VIII, IX)

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-I-18

Subject: Review of AMA Educational Offerings

Presented by: Carol Berkowitz, MD, Chair

INTRODUCTION

The Council on Medical Education has been gratified to observe our American Medical Association's (AMA) committed investment in and focus on the development and provision of high-quality educational resources and initiatives for physicians and physicians in training, and is pleased to be able to highlight these to members of the House of Delegates (HOD).

THE EARLY YEARS: THE AMA'S COUNCIL ON MEDICAL EDUCATION

Our AMA's commitment to medical education dates to the founding of the Association in 1847, when one of its first acts was to appoint a body known as the Committee on Medical Education. The Committee on Medical Education was transformed into the Council on Medical Education in 1904; an addition to AMA bylaws in that year noted that:

The functions of the Council on Medical Education shall be:

- To make an annual report to the House of Delegates on the existing conditions of medical education in the United States.
- To make suggestions as to the means and methods by which the American Medical Association may best influence favorably medical education.
- To act as the agent of the American Medical Association (under instructions from the House of Delegates) in its efforts to elevate medical education.¹

In 1905, the Council published its first set of educational standards for medical schools, recommending (1) that medical schools require preliminary education sufficient to enable the candidate to enter a recognized university; (2) a 5-year medical course; and (3) a sixth year as an intern in the hospital.²

In 1906, the Council, tasked with rating U.S. medical schools, surveyed 160 schools regarding the performance of graduates on state licensure examinations. Schools were graded as acceptable, doubtful, or non-acceptable based on a set of ten defined qualifications. Only 82 schools received an "acceptable" rating. This led to the Council's 1909 partnership with the Carnegie Foundation on a new study of medical schools; the results of this study were published in 1910 in the Flexner Report.³

In the intervening years, our AMA, through the Council on Medical Education and other groups, has been involved in the establishment of many of the leading U.S. medical education organizations that exist today and with the development of multiple educational innovations. These organizations and innovations are summarized in Appendix A.

EXPANDING OUR AMA'S EDUCATION DEVELOPMENT AND DELIVERY CAPABILITIES

Our AMA has recently dedicated additional resources and staff to its educational initiatives, and as a result, numerous innovations are being developed.

Content

In-house instructional design capabilities have been enhanced, and measures have been taken to ensure educational content incorporates learning trends that engage adult learners. Additionally, our AMA has developed a library of templated eLearning interactions, which can be leveraged across the organization in content development efforts. A robust quality rubric has been implemented to guide the planning, development, and evaluation of education. The rubric helps to ensure that education is well-designed and likely to result in achieving the desired learning outcomes. Finally, the assessment creation process has been improved to better evaluate mastery of learning objectives.

Platform

Our AMA plans to launch a unified education delivery platform known as the AMA Ed Hub™. The AMA Ed Hub™ will bring together our AMA's diverse educational offerings under a unified umbrella, including [JN Learning™](#); the [GME Competency Education Program](#) (GCEP); e-learning modules that support our AMA's *Health Systems Science* (HSS) textbook; interactive micro-learning modules based on our AMA's modernized [Code of Medical Ethics](#); the [STEPS Forward™](#) practice transformation series; and curricula related to pain management, firearm safety, and other topics.

The platform will blend innovations in content, technology, and user experience to deliver increasingly more personalized and compelling virtual learning experiences to meet individual needs and preferences. Additionally, it will feature trusted education in engaging and multi-dimensional formats to satisfy a variety of preferences (audio, interactive, journal, and video). The platform is designed to facilitate easy discovery of relevant education. All content is standardized, tagged, and enriched in a way that allows our AMA to actively engage learners by offering content across many channels, sites, apps, and products.

OUR AMA'S EDUCATIONAL INITIATIVES AND RESOURCES

Our AMA is also proactively seeking cooperation between business units to mine additional educational content, more effectively leverage subject matter expertise across products, and expand target audiences. For example, authors of the HSS textbook have extended their contributions beyond medical school to residency by contributing to the development of GME Competency Education Program educational modules. Also, education regarding physician burnout has been repackaged to focus on burnout at the resident physician level.

Accelerating Change in Medical Education Consortium innovations

Our AMA's [Accelerating Change in Medical Education](#) initiative, launched in 2013, has fostered a culture of medical education advancement, leading to the development and scaling of innovations at the undergraduate medical education level across the country. After awarding initial grants to 11 U.S. medical schools, the AMA convened these schools to form the Accelerating Change in Medical Education Consortium—an unprecedented collective that facilitated the development and

1 communication of groundbreaking ideas and projects. The AMA awarded grants to an additional
2 21 schools in 2016. Today, almost one-fifth of all U.S. allopathic and osteopathic medical schools
3 are represented in the 32-member consortium, which is delivering revolutionary educational
4 experiences to approximately 19,000 medical students—students who one day will provide care to
5 a potential 33 million patients annually.

6
7 A summary of innovations resulting from the Consortium can be found in Appendix B.
8 Additionally, a comprehensive, annotated bibliography of publications based on the work of the
9 Consortium has been published and is available for review.⁴

10 11 *Innovative Educational Formats in the JAMA Network*

12
13 The JN Listen™ app provides learners with convenient access to engaging podcasts based on peer-
14 reviewed articles published in *JAMA*. Learners can listen to content they select and earn CME, all
15 via the mobile app.

16 17 *STEPS Forward™*

18
19 The AMA STEPS Forward™ practice transformation series is an online educational product
20 designed to offer innovative strategies that assist physicians in the new health care environment.
21 Leveraging findings from an AMA-RAND study,⁵ the online modules provide clinicians and
22 practice managers with the data, tools, education, and certification needed to be successful in a
23 value-based payment environment. Learners can take courses about patient care, workflow and
24 process, and professional well-being, among other topics. All STEPS Forward™ modules are
25 Centers for Medicare & Medicaid Services-approved Clinical Practice Improvement Activities; by
26 completing these modules, physicians can demonstrate compliance with Merit-Based Incentive
27 Payment System requirements.

28
29 Recently, each of the 48 available modules' learning objectives and assessments were revised to
30 ensure that learner expectations and outcomes are aligned. Content is currently being converted to a
31 standardized format for multichannel publication.

32 33 *GME Competency Education Program*

34
35 The AMA GME Competency Education Program (GCEP) comprises a series of online educational
36 modules designed to complement teaching in patient settings and didactic curricula in residency
37 and fellowship programs. The program helps residents and their institutions meet core competency
38 requirements. In 2018, GCEP was selected as a Gold winner in the 2018 Digital Health Awards,
39 which recognizes high-quality digital health resources for health professionals.

40
41 Over the past year, the 33-module GCEP library has been upgraded to add animation, case
42 vignettes, and mock simulations to help residents visualize how the content is applicable to their
43 daily practice. The final eight modules are currently being enhanced, including content on quality
44 improvement practices, promoting medication adherence, navigating a lawsuit, and creating an
45 effective and respectful learning environment, among other topics. Personalized instruction has
46 been incorporated, as well as guided learning using relatable mentor characters.

47 48 *Health Systems Science*

49
50 In addition to basic and clinical sciences, recognition is growing that physicians also need to know
51 HSS, understanding how care is delivered, how patients receive that care, and how systems

function to improve health. By the end of 2018, the AMA plans to have completed six e-learning modules for medical students that complement the HSS textbook, with the goal of providing a cohesive introduction to HSS. While the initial target audience is medical students, faculty development components will be included. Eventually, a parallel learning strategy for faculty and residents is also envisioned. Current modules in development include systems thinking, patient safety, and population health.

Ethics

In 2017, our AMA adopted the modernized *Code of Medical Ethics*,⁶ and new, interactive micro-learning modules have been created around key *Code* opinions. In 2018, the AMA has been developing new modules on privacy and confidentiality, surrogates, and physicians as leaders.

Health Equity

To support the work stemming from our AMA's newly adopted policy related to health equity,⁷ a new module has been launched titled Collecting Patient Data: Improving Health Equity in Your Practice.

The AMA Physician's Recognition Award and Credit System

The AMA Physician's Recognition Award (PRA), established by the HOD in December 1968 and celebrating its 50th anniversary in 2018, recognizes physicians who, by participating in CME activities, have demonstrated their commitment to staying current with advances in medicine. The AMA PRA credit system was developed to describe CME activities with sufficient educational value that could be counted towards the requirements to obtain the PRA. AMA PRA credit is the most widely accepted CME credit used by physicians of all specialties to document CME participation for licensing boards, certification boards, hospital credentialing committees, insurance groups, and other organizations.

The AMA PRA credit system has continued to respond to the needs of physicians and to changes in the practice of medicine. Recognizing that physicians learn in different ways and that a variety of educational formats should be recognized for credit, the Council on Medical Education has approved new educational formats for *AMA PRA Category 1 Credit*TM over the years in addition to the original formats of live certified activities and enduring materials. Subsequently approved formats include Journal-Based CME (1998), Manuscript Review (2003), Test Item Writing (2003), Performance Improvement CME (2004), and Internet Point-of-Care (2005). Most recently, in 2017, the Council on Medical Education approved a format of "Other" for those activities that meet core requirements but do not fall within one of the already existing formats.

The AMA PRA credit system also operates beyond U.S. borders. In 1990, the HOD adopted a Council on Medical Education report to establish a process for qualified international conferences to offer *AMA PRA Category 1 Credit*TM to attendees. The International Conference Recognition Program continues to this day, and international opportunities to earn *AMA PRA Category 1 Credit*TM have expanded to include activities covered by agreements between the AMA and the credit systems of other regions and nations. Three agreements currently exist, with the European Union of Medical Specialists, the Royal College of Physicians and Surgeons of Canada, and the Qatar Council for Healthcare Practitioners.

1 *Section/Council Educational Sessions*

2
3 Since 2014, AMA sections and/or councils have produced approximately 120 educational sessions
4 at the Annual and Interim meetings (15 sessions per meeting, on average), in addition to various
5 other activities provided throughout the years. Nationally renowned experts, including many AMA
6 members, have educated on important and timely topics, such as physician burnout, the opioid
7 epidemic, firearm safety, value-based care, physician leadership, and innovation.
8

9 *Collaboration with External Organizations*

10
11 Our AMA continues to work to lessen the administrative burden for physicians by simplifying and
12 streamlining the automatic tracking and reporting of credit to support certification and licensure
13 needs. Currently, our AMA partners with the ACCME and ABIM to report completed JAMA
14 Network CME activities on behalf of physicians certified by the ABIM. The AMA will extend
15 these reporting capabilities to include all AMA educational activities and additional ABMS
16 member boards in 2019. Finally, a pilot is being planned with the ACCME and Board of Medical
17 Examiners in Tennessee to report completed activities on behalf of physicians licensed in
18 Tennessee.
19

20 Our AMA has also been approved as an ABMS Multi-Specialty Portfolio Program sponsor and has
21 developed CME programs that are eligible for continuing certification (MOC Part IV) credit.
22

23 *Future Innovations*

24
25 Additional planned innovations will focus on educational features and apps that offer innovation in
26 the education space. Currently, our AMA is:
27

- 28 • Leveraging augmented intelligence to power learning experiences;
- 29 • Taking new approaches to documenting meaningful involvement in performance
30 improvement; and
- 31 • Considering different types of assessment, which could expand the content for which credit
32 can be offered.
33

34 Finally, our AMA is also exploring the potential of the AMA Ed Hub™ platform to be of service to
35 other educational providers.
36

37 **SUMMARY**

38
39 For 150 years, our AMA has demonstrated a commitment to developing and supporting
40 advancements in medical education, both autonomously and in partnership with others. From the
41 Council on Medical Education's contributions to the Flexner Report, to the groundbreaking
42 Accelerating Change in Medical Education Consortium, to newly enhanced e-learning content
43 design and delivery, our AMA is well positioned to lead medical education innovations into the
44 next century.

APPENDIX A: THE AMA'S INFLUENCE IN ESTABLISHING MANY LEADING U.S. MEDICAL EDUCATION ORGANIZATIONS AND DEVELOPING EDUCATIONAL INNOVATIONS

1847	The American Medical Association is organized and the Committee on Medical Education is formed.
1904	The AMA transforms the Committee on Medical Education into the Council on Medical Education (Council).
1905	The Council publishes its first set of educational standards for medical schools.
1906	The Council performs its first inspection of medical schools.
1910	The Council's partnership with the Carnegie Foundation leads to the publication of the Flexner Report.
1912	The Council fields its first survey of hospitals for the training of interns.
1919	The Council establishes the "Essentials" for approved Internships.
1920	The Council organizes 15 committees to study and "recommend what preparation was deemed essential to secure expertness in each of the specialties"; these committees represent the forerunners of today's boards.
1927	The Council begins approval of residency programs in hospitals.
1928	The Council establishes "Essentials" for registered hospitals and for approved residencies and fellowships.
1934	The Council approves examining boards for the certification of specialists and establishes standards for the formation of American boards in the specialties.
1939	The Council, with the American Board of Internal Medicine (ABIM) and American College of Physicians (ACP), forms the Conference Committee on Graduate Training in Internal Medicine, later to become the Residency Review Committee for Internal Medicine; other specialty boards soon request their own committees.
1942	At the request of the Council, the AMA Board of Trustees and the Association of American Medical Colleges (AAMC) form the Liaison Committee on Medical Education (LCME).
1948	The Council and the Advisory Board for Medical Specialties establish the Liaison Committee for Specialty Boards.
1950	The Council establishes the Conference Committee on Graduate Training in Surgery.
1954	With representation from the Council, the AAMC, the American Hospital Association (AHA), and the Federation of State Medical Boards (FSMB), an Internship Review Committee is established to review the reports of surveys of intern training programs made by members of the Council's field staff.

- 1955 Based on work performed by the Council, the “Publication of Postgraduate Medical Education in the United States: A Report of the Survey of Postgraduate Medical Education Carried Out by the Council on Medical Education and Hospitals” is published.
- 1957 A guide on postgraduate medical education (continuing medical education) is issued.
- 1957 With the AHA, AAMC, and FSMB, the Council sponsors the organization of the Educational Commission for Foreign Medical Graduates (ECFMG).
- 1962 The AMA completes the first accreditation survey of continuing medical education (CME) sponsors; the lists of accredited sponsors are published in *JAMA*.
- 1967 The Advisory Committee on Continuing Medical Education, of the AMA House of Delegates, develops a nationwide accreditation system for CME providers.
- 1968 The AMA establishes the AMA Physician’s Recognition Award (PRA) to recognize physicians who earn at least an average of 50 credits per year from educational activities that meet AMA standards and the AMA PRA CME credit system.
- 1970 The Advisory Board for Medical Specialties is reorganized as the American Board of Medical Specialties (ABMS).
- 1971 The Council establishes the Liaison Committee on Graduate Medical Education, which later becomes the Accreditation Council for Graduate Medical Education (ACGME).
- 1977 The Council establishes the Liaison Committee on Continuing Medical Education (LCCME).
- 1981 The AMA, with the AAMC, AHA, FSMB, ABMS, Association for Hospital Medical Education, and Council of Medical Specialty Societies, creates the Accreditation Council for Continuing Medical Education (ACCME) as successor to the LCCME for the accreditation of CME sponsors.
- 1982 CME Report B, Recommendations for “Future Directions for Medical Education,” is adopted by the AMA House of Delegates.
- 1987 CME Report C, “Resident Working Hours and Supervision,” is adopted by the AMA House of Delegates.
- 1991 The AMA’s Fellowship and Residency Electronic Interactive Data Access (FREIDA) System is established.
- 1996 The Council on Medical Education approves *AMA PRA Category 1 Credit™* for reading journal articles.
- 1996 AMA FREIDA becomes AMA FREIDA Online®.

- 2000 The Council approves its first international agreement for the conversion of CME credits, providing physicians the opportunity to receive *AMA PRA Category 1 Credit™* for attending European Union of Medical Specialists educational activities certified for credit. Other agreements would follow.
- 2002 CME Report 9, “Resident Physician Working Conditions,” is adopted by the AMA House of Delegates.
- 2003 The Council on Medical Education approves *AMA PRA Category 1 Credit™* for test item writing and manuscript review learning formats.
- 2004 The Council on Medical Education approves *AMA PRA Category 1 Credit™* for Performance Improvement CME (PI CME) learning format.
- 2005 The Council on Medical Education approves *AMA PRA Category 1 Credit™* for Internet Point of Care learning format.
- 2005 The AMA embarks on its Initiative to Transform Medical Education (ITME).
- 2006 The Alliance for CME awards the AMA the Frances M. Maitland PACME Award for “significant contribution to the field of CME and the future of the profession.”
- 2006 The AMA trademarks the phrase *AMA PRA Category 1 Credit™*.
- 2006 Phase 2 of ITME begins, resulting in recommendations for change across the continuum to address identified gaps in medical education.
- 2007 Phase 3 of ITME begins with a working conference on Optimizing the Medical Education Learning Environment.
- 2008 Phase 3 of ITME continues with a conference in collaboration with the American Academy of Pediatrics on Physician Reentry into Practice.
- 2009 The AMA and Association of American Medical Colleges hold ITME Conference on Increasing Attention to Behavioral Competencies in the Admissions Process.
- 2010 The AMA and AAMC co-sponsor an invitational conference, “New Horizons in Medical Education: A Second Century of Achievement.”
- 2011 The AMA Innovative Strategies for Transforming the Education of Physicians (ISTEP) research collaborative begins the second stage of its study of the medical education learning environment.
- 2012 The AMA announces a new strategic plan to focus on Accelerating Change in Medical Education as one of its three main focus areas.
- 2012 The AMA and AAMC sign a formal agreement that outlines their joint, ongoing commitment to supporting the medical education accreditation process.

- 2013 The AMA announces grant funding for medical school innovations and awards \$11 million to 11 medical schools nationwide as part of its Accelerating Change in Medical Education initiative.
- 2013 The AMA PRA recognizes teaching students and residents as an *AMA PRA Category 1 Credit™* activity.
- 2013 The AMA launches its Save GME grassroots campaign (saveGME.org) to urge Congress to preserve GME funding and lift the federal cap on residency slots.
- 2014 The AMA is among the four signers of a formal agreement between the LCME and the Committee on Accreditation of Canadian Medical Schools (CACMS) to ensure medical school graduates in both the United States and Canada meet their respective countries' standards and are prepared for the next phase of their medical training.
- 2014 The Council on Medical Education convenes a conference with the ABMS and its member boards to discuss ways to improve Maintenance of Certification and make the process more meaningful for physicians.
- 2015 The AMA awards grants to an additional 21 medical schools as a part of the Accelerating Change in Medical Education Consortium, further expanding this community of learning.
- 2018 The Council on Medical Education co-convenes a second conference with the ABMS and its member boards to discuss the future of continuing certification.

APPENDIX B: SUMMARY OF CONSORTIUM INNOVATIONS IN MEDICAL EDUCATION⁸

INNOVATION FOCUS	SUMMARY	PUBLICATIONS AND OUTCOMES
Developing flexible, competency-based pathways	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.	Generalizing Competency Assessment Scores Across and Within Clerkships⁹ Finding a Path to Entrustment in Undergraduate Medical Education¹⁰ Constructing a Shared Mental Model for Faculty Development in CEPAER¹¹
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.	<i>Health Systems Science</i>¹² Investigate the Barriers to Integrating Health Systems Science in Medical Education¹³ Science of Health Care Delivery Milestones for Undergraduate Medical Education¹⁴
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.¹⁵ Socially Accountable Medical Education: An Innovative Approach at Florida International University

	improving the health of patients in meaningful ways.	Herbert Wertheim College of Medicine ¹⁶ Value-Added Clinical Systems Learning Roles for Medical Students That Transform Education and Health: A Guide for Building Partnerships Between Medical Schools and Health Systems ¹⁷
Making technology work for learning	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.	Regenstrief EHR Clinical Learning Platform¹⁸ Barriers to Medical Students' Electronic Health Record Access Can Impede Their Preparedness for Practice.¹⁹ NYU Langone Health: Healthcare by the Numbers: Populations, Systems, and Clinically Integrated Data²⁰
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.	Fostering the Development of Master Adaptive Learners: A Conceptual Model to Guide Skill Acquisition in Medical Education.²¹ Mission Control: The Gamification of Medical Learning²²
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.	Shifting the Curve: Fostering Academic Success in a Diverse Student Body²³ Medical Student Perceptions of the Learning Environment: Learning Communities Are Associated With a More Positive Learning Environment in a Multi-Institutional Medical School Study²⁴

Universal outcomes		Coaching Handbook²⁵ Curricular Transformation: The Case Against Global Change²⁶ Why Not Wait? Eight Institutions Share Their Experiences Moving United States Medical Licensing Examination Step 1 After Core Clinical Clerkships.²⁷ Turn Med Ed on its Head: Medical Education Innovation Challenge.²⁸
Creating an online community	Participants in this online community are discussing developments and innovations in medical education, including the work emerging from the AMA's Accelerating Change in Medical Education Consortium, as part of the AMA's work to create the medical schools of the future. Webinars educate and connect participants and help spread innovations nationally.	Implementing a Teaching EHR as a Clinical Learning Platform²⁹ Transforming Education: Leading Innovations in Health Professions Education³⁰ Using Big Data to Teach Population Health³¹ Health Systems Science: The Third Pillar of Medical Education³² Interprofessional Education: Using Technology to Teach Team-Based Care³³ To Medical Student Wellness and Beyond: Creating a Healthy Culture for All³⁴ Leadership Training: Developing the Next Generation of Physician Leaders Portfolios and Dashboards: Leveraging Data for Student Success

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 7-I-18

Subject: 50th Anniversary of the AMA Physician's Recognition Award and Credit System

Presented by: Carol Berkowitz, MD, Chair

INTRODUCTION

The American Medical Association (AMA) is celebrating the 50th anniversary of the AMA Physician's Recognition Award (PRA) this year. This report regarding the AMA PRA, and the credit system that was developed to support this award, is submitted to the House of Delegates (HOD) for informational purposes.

The AMA has played a central role in the development of continuing medical education (CME) in the United States by developing the AMA PRA credit system, which codified the requirements and standards for earning *AMA PRA Category 1 Credit™* and *AMA PRA Category 2 Credit™*. The AMA PRA was established by the HOD in December 1968 to recognize physicians who, by participating in CME activities, have demonstrated their commitment to staying current with advances in medicine. The 1968 report adopted by the HOD that established the AMA PRA included the following goals:

1. To provide recognition for the many thousands of physicians who regularly participate in CME.
2. To encourage each physician to keep up-to-date and to improve knowledge and judgment by CME.
3. To provide reassurance to the public that America's physicians are maintaining their competence by regular participation in CME.
4. To emphasize the AMA's position as a leader in CME.
5. To emphasize the importance of developing more meaningful continuing education opportunities for physicians.

STATUS OF THE AMA PRA AND CREDIT SYSTEM

AMA PRA credit is the most widely accepted CME credit used by physicians of all specialties to document CME participation for licensing boards, certification boards, hospital credentialing committees, insurance groups, and other organizations. A total of 50 U.S. jurisdictions, including 45 states, four territories, and Washington, DC, currently have CME requirements for licensure of physicians; all recognize AMA PRA credit to fulfill these requirements. Many jurisdictions accept the AMA PRA certificate or an approved AMA PRA application as documentation of meeting their CME requirements.

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.

1 CURRENT AMA POLICY

2
3 AMA policies related to this topic are listed in the Appendix.

4
5 SUMMARY

6
7 The past 50 years have seen many changes in CME, and the AMA has led many of these changes
8 by adapting the AMA PRA and the credit system to include new concepts, introduce new ideas,
9 and recognize the multiple ways in which physicians learn and improve. The AMA PRA credit
10 system must continue to be responsive to the needs of physicians to ensure they are adequately
11 recognized for their participation in certified CME activities. To achieve this goal, the Council on
12 Medical Education recognizes the importance of its continued stewardship of this valuable process.

13
14 As the AMA celebrates the 50th anniversary of this award, the Council on Medical Education
15 would like to draw attention to Policy H-300.959, "Physician Participation in the AMA Physician's
16 Recognition Award," which states that: "(1) the AMA, state medical societies, and specialty
17 societies in the AMA House of Delegates publicize and promote physician participation in the
18 AMA Physician's Recognition Award; and (2) that all physicians participate in the AMA
19 Physician's Recognition Award as a visible demonstration of their commitment to continuing
20 medical education." (CME Rep. 1, I-93; Reaffirmed with change in title: CME Rep. 2, A-05;
21 Reaffirmed: CME Rep. 1, A-15)

APPENDIX: RELEVANT AMA POLICY

H-275.917, “An Update on Maintenance of Licensure”

3. Our AMA will: A. Continue to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for continuing medical education in the United States, including the Performance Improvement CME (PICME) format, and continue to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME as part of the process for MOL.

H-275.924, “Maintenance of Certification”

AMA Principles on Maintenance of Certification (MOC): 10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the United States, including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

H-295.926, “Support for Development of Continuing Education Programs for Primary Care Physicians in Non-Academic Settings”

The AMA: (1) supports development, where appropriate, of programs of education for medical students and faculty in non-academic settings, making use of telecommunications as needed; (2) encourages that medical schools provide faculty development programs that are designated for *AMA PRA Category 1 Credit™*; and (3) encourages that teaching continue to be accepted for *AMA PRA Category 2 Credit™* when not designated for *AMA PRA Category 1 Credit™*.

H-300.955, “Restructuring of Continuing Medical Education Credits”

The AMA encourages state licensing boards with CME reporting requirements to allow *AMA PRA Category 1 Credit™* and *AMA PRA Category 2 Credit™* toward reregistration of the license to practice medicine; and all state licensing boards be urged to accept a current and valid AMA Physician’s Recognition Award as evidence of completion of these requirements.

H-300.959, “Physician Participation in the AMA Physician’s Recognition Award”

It is policy that: (1) the AMA, state medical societies, and specialty societies in the AMA House of Delegates publicize and promote physician participation in the AMA Physician’s Recognition Award; and (2) that all physicians participate in the AMA Physician’s Recognition Award as a visible demonstration of their commitment to continuing medical education.

H-300.974, “Unification of Continuing Education Credits”

Our AMA accepts American Academy of Family Physicians prescribed credit hours and American College of Obstetricians and Gynecologists cognate credit hours for formal learning, as equivalent to *AMA PRA Category 1 Credit™*.

H-300.977, “Revisions to the Physician’s Recognition Award”

Our AMA has adopted the following changes in the Physician’s Recognition Award: (1) to accept recertification by an AMA-recognized specialty board in satisfaction of requirements for a three-year PRA certificate; (2) to allow credit for international conferences when these have been approved by the AMA prior to the event; and (3) to allow credit for teaching to be reported for *AMA PRA Category 2 Credit™* toward the award.

D-300.999, “Registration of Accredited CME Sponsors”

1. Our AMA will continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician’s Recognition Award (PRA) policy when designating AMA PRA credit. 2. Our AMA will remind all accredited CME providers of their responsibility, as stated in the AMA PRA requirements, to provide documentation to participating physicians of the credit awarded at the request of the physician.

H-480.974, “Evolving Impact of Telemedicine”

Our AMA: (7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician’s Recognition Award, for educational consultations using telemedicine...

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 8-I-18

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

Presented by: Carol Berkowitz, MD, Chair

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

3
4 That our American Medical Association determine the most efficient and accurate mechanism
5 to study the actual incidence of medical student, resident, and physician suicide, and report
6 back at the 2018 Interim Meeting of the House of Delegates with recommendations for action.
7

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

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

REPORT OF THE SPEAKERS

Speakers' Report I-18

Subject: Recommendations for Policy Reconciliation

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

1 Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," calls on your Speakers to
2 "present one or more reconciliation reports for action by the House of Delegates relating to newly
3 passed policies from recent meetings that caused one or more existing policies to be redundant and/or
4 obsolete."
5

6 Your Speakers present this report to deal with policies, or portions of policies, that are no longer
7 relevant or that were affected by actions taken at the recent Annual Meeting. Suggestions on other
8 policy statements that your Speakers might address should be sent to hod@ama-assn.org for possible
9 action. Where changes to language will be made, additions are shown with underscore and deletions
10 are shown with strikethrough.
11

12 RECOMMENDED RECONCILIATIONS

13 *Obsolete references to be deleted from policies*

14
15
16 Policy G-600.031 characterizes the roles and responsibilities of delegates and alternate delegates. The
17 policy dates from 1999 and was most recently reaffirmed at the 2012 Annual Meeting. Your Speakers
18 regard it as an important policy, but it includes a reference to a program that no longer exists. That
19 clause will be deleted and a minor editorial change made.
20

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

22 (1) Members of the AMA House of Delegates serve as an important communications, policy, and
23 membership link between the AMA and grassroots physicians. The delegate/alternate
24 delegate is a key source of information on activities, programs, and policies of the AMA. The
25 delegate/alternate delegate is also a direct contact for the individual member to communicate
26 with and contribute to the formulation of AMA policy positions, the identification of
27 situations that might be addressed through policy implementation efforts, and the
28 implementation of AMA policies. Delegates and alternate delegates to the AMA are expected
29 to foster a positive and useful two-way relationship between grassroots physicians and the
30 AMA leadership. To fulfill these roles, AMA delegates and alternate delegates are expected
31 to make themselves readily accessible to individual members by providing the AMA with
32 their addresses, telephone numbers, and email addresses so that the AMA can make the
33 information accessible to individual members through the AMA Web site and through other
34 communication mechanisms.
35

36 (2) The roles and responsibilities of delegates and alternate delegates are as follows: (a) regularly
37 communicate AMA policy, information, activities, and programs to constituents so he/she
38 will be recognized as the representative of the AMA; (b) relate constituent views and

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,

1 “Management of Physician and Medical Student Stress” that fulfilled the request. Therefore the
2 directive will be rescinded.

3
4 D-405.982, “Management of Physician and Medical Student Stress

5 Our AMA will produce a report on administrative and regulatory burdens placed on physicians,
6 residents and fellows, and medical students, and pursue strategies to reduce these burdens.

7
8 CHANGES IN TERMINOLOGY

9
10 The following policy statements were updated to comport with AMA style and usage in references to
11 continuing medical education credit for the AMA Physician’s Recognition Award. PolicyFinder now
12 employs an italic typeface and the trademark (™) symbol in references to *AMA PRA Category 1*
13 *Credit™* or *AMA PRA Category 2 Credit™*. The prior version of PolicyFinder did not allow these
14 features. We point this out primarily to alert members of the House to the correct usage. It also
15 happens that this year is the 50th Anniversary of the AMA Physician’s Recognition Award and Credit
16 System.

17
18 The affected policies are:

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

25
26 The changes outlined above do not reset the sunset clock and will be implemented when this report is
27 filed.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(I-18)

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

Subject: Creation of an AMA Election Reform Committee

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

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;⁷⁻⁹ 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

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3. Weir, K. (2014). Is pornography addictive? *American Psychological Association*. 2014: 45(4):46.
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7. Janet, H. S. When words are not enough: The search for the effect of pornography on abused women. *Violence Against Women*. 2004; 10(1), 56-72.
8. Romito, P., & Beltramini, L. Watching pornography: Gender differences, violence and victimization. an exploratory study in Italy. *Violence Against Women*. 2011: 17(10), 1313-1326.
9. Simmons, C. A., Lehmann, P., & Shannon Collier-Tenison. Linking male use of the sex industry to controlling behaviors in violent relationships: An exploratory analysis. *Violence Against Women*. 2008;14(4):406-417.

RELEVANT AMA POLICY**Child Pornography H-60.990**

The AMA (1) encourages and promotes awareness of child pornography issues among physicians; (2) promotes physician awareness of the need for follow-up psychiatric treatment for all victims of child pornography; (3) encourages research on child abuse (including risk factors, psychological and behavioral impact, and treatment efficacy) and dissemination of the findings; and (4) wherever possible, encourages international cooperation among medical societies to be alert to and intervene in child pornography activities.

Citation: BOT Rep. Z, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934

Our AMA:

- (1) Recognizes the positive role of the Internet in providing health information to children and youth.
- (2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
- (3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.
- (4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.
- (5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.

Citation: BOT Rep. 10, I-06; Modified: CSAPH Rep. 01, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 909
(I-18)

Introduced by: Wisconsin

Subject: Use of Person-Centered Language

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

Whereas, Communication is one of the foundational aspects of patient care that impacts patient satisfaction and builds rapport between a physician and patient;¹ and

Whereas, Person-first language is a style of communication in which the person is listed first followed by descriptive terms, such as a disease state (e.g. “a person with schizophrenia” rather than “a schizophrenic”), which avoids defining a person by his or her disease state and places the emphasis on the person rather than the disease or disability; and

Whereas, The use of person-first language may improve the doctor-patient relationship,² encourage a healthy relationship between researchers and the community,^{3,4} and may reduce stigma associated with certain disease states;^{5,6} and

Whereas, Multiple organizations including the federal Centers for Disease Control and Prevention, American Psychological Association, and American Society of Addiction Medicine encourage person-first language;^{7,8,9,10,11,12} and

Whereas, Person-centered language is a style of communication that incorporates an individual's preference and identity when referring to a disease state (e.g. “a blind person” or “a person with blindness” based on personal preference), which may deviate from person-first language; and

Whereas, The use of person-centered language focuses on each person's individual preferences rather than using generalizing terms for a group when referring to a disease state or disability, which seeks to maintain dignity and respect for all individuals;^{13,14} and

Whereas, Certain groups - such as the deaf and the blind communities - speak against using person-first language because they identify their disability as a trait they possess instead of a pathologic process, and this issue is mitigated by using person-centered language;^{15,16} and

Whereas, The Canadian Alzheimer's Society has developed specific guidelines for using person-centered language as to “not diminish the uniqueness and intrinsic value of each person and to allow a full range of thoughts, feeling and experiences to be communicated,” and to continue to build trusting relationships with these patients regardless of their condition;¹³ and

Whereas, The AMA recommends the use of person-first language in the AMA Code of Style, and recently adopted policy regarding the use of person-first language for obesity (H-440.821) but failed to include other disease states; therefore be it

- 1 RESOLVED, That our American Medical Association encourage the use of person-centered
2 language. (New HOD Policy)

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

Received: 09/25/18

RELEVANT AMA POLICY

Person-First Language for Obesity H-440.821

Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully.

Citation: Res. 402, A-17; Modified: Speakers Rep., I-17

References:

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 910
(I-18)

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

Subject: Shade Structures in Public and Private Planning and Zoning Matters

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

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} and

Whereas, The Surgeon General's "Call to Action to Prevent Skin Cancer" of 2014⁵ 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

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