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

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

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

15 BACKGROUND

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

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

28 The cost to law enforcement entities to implement and maintain a body camera program can be
29 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

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

4

5 *Community Relations*

6

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

16

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

23

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

32

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

39

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

45

46 *Privacy Considerations*

47

48 Though the use of body cameras promises greater transparency of law enforcement behavior and
49 actions, they also present new problems, namely intrusion into the privacy of victims, witnesses
50 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

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

4
5 These privacy concerns could be addressed with policies to limit recording during such encounters
6 and by limiting the circumstances under which recordings are made available to the public. The
7 American Civil Liberties Union (ACLU) recommends use of body cameras with significant
8 privacy protections. Officer privacy may also be a concern. Some law enforcement unions have
9 opposed body-worn cameras, arguing that adoption of the technology must be negotiated as part of
10 the collective bargaining agreement.

11
12 This report acknowledges the significant privacy concerns raised by the ubiquitous use of body-
13 worn cameras, but notes that questions about when cameras need to be turned on and off, how long
14 to keep footage, when recordings will be made publicly available and other policy details are
15 beyond the expertise of the AMA.

16
17 *Nexus with the AMA's Mission*

18
19 The AMA does not have policy specifically addressing the use of body-worn cameras among law
20 enforcement. During the debate over Resolution 208 during the 2017 Interim Meeting, the
21 reference committee heard testimony questioning whether this topic is within the scope of the
22 AMA's expertise. This concern is reasonable, as AMA has not historically delved into issues of
23 policing and significant resources would be required to bring the AMA into the public policy
24 debates surrounding community policing efforts. Further, while there are dozens of organizations
25 (the Police Executive Research Forum, Leadership Conference on Civil and Human Rights, ACLU,
26 etc.) that are actively engaged on this issue, it does not appear that any other major medical
27 associations have emerged as significant stakeholders.

28
29 Nevertheless, there is a connection between health and police activity, particularly in terms of
30 minority fatality rates. Research has demonstrated that minority communities are disproportionately
31 subject to police force. Specifically, according to an analysis of FBI statistics, African-Americans
32 account for 31 percent of police-involved shootings, but comprise 13 percent of the U.S.
33 population.⁴ African-American males are particularly at risk. According to another analysis,
34 African-American males are three times more likely to be killed by police than non-Hispanic white
35 males.⁵

36
37 Research has also shown a correlation between policing and other health outcomes. In particular, a
38 recent study found that police killings of unarmed African-Americans were associated with
39 1.7 days of poor mental health annually among African-Americans. The findings were seen
40 regardless of whether the individual affected had a personal relationship with the victim or whether
41 the incident was experienced vicariously. In addition, the numbers of police stops, coupled with the
42 level of invasiveness during police encounters, is associated with increased levels of stress and
43 anxiety.^{17,18} African-American men report more anxiety and post-traumatic stress disorder and
44 more morbidity from these psychiatric conditions than Caucasian men.⁵ In addition, research of
45 data from the New York Police Department revealed that residents in neighborhoods with higher
46 rates of stop-and-frisks were more likely to be in poor health, measured in terms of high blood
47 pressure, diabetes, asthma and self-rated health.¹⁸ Research on the correlation between health and
48 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 At the 2017 Interim Meeting, the House of Delegates referred Resolution 211-I-17, "Exclusive
3 State Control of Methadone Clinics," introduced by the Indiana Delegation, which asked:

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

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

12 DISCUSSION

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

19 There are more than 1,600 certified opioid treatment programs (OTPs) offering methadone in the
20 U.S.² According to the Substance Abuse and Mental Health Services Administration (SAMHSA),
21 the number of persons receiving methadone increased by 34 percent from 2006 (258,752) to
22 2016 (345,443).³ With respect to opioid-related mortality, deaths attributed to methadone increased
23 rapidly from 1999 (784 deaths) to their peak in 2007 (5,518) and have steadily declined since with
24 3,373 methadone-related deaths in 2016, according to the Centers for Disease Control and
25 Prevention.⁴ It is beyond the scope of this report to detail whether the methadone use in these
26 deaths was for the treatment of pain, for opioid use disorder, related to illicit use or was a
27 complicating polypharmacy factor.

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

1 *FDA Regulatory Authority*

2
3 Within the broad scope of FDA's regulatory authority is the review and approval of drugs, both
4 brand name and generic. A general overview of the FDA process can be found online:
5 <https://www.fda.gov/Drugs/DevelopmentApprovalProcess/default.htm#FDA>. With respect to
6 methadone, the FDA approved a New Drug Application for methadone in 1947. There were
7 intervening actions, but for the purposes of this report, the FDA issued regulations for methadone
8 Investigational New Drugs in 1971; proposed new regulations in April 1972; and issued final
9 regulations in December 1972.⁵

10 *DEA Regulatory Authority*

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

16 *HHS Regulatory Authority*

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

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

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

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

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

36 *State Authority*

37 There are numerous areas where state regulatory authority and linkages with federal oversight exist
38 regarding OTPs. One prominent area concerns who shall serve as the medical director of the OTP.
39 Federal regulations require that the medical director must be "a physician licensed to practice
40 medicine in the jurisdiction in which the [OTP] is located." State licensure is squarely within the
41 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 2. That our AMA encourage state governments to collaborate with health insurance companies
44 and other payers, state medical societies, national medical specialty societies, OTPs and other
45 health care organizations to develop and disseminate resources that identify where OTP
46 providers operate in a state and take part in surveillance efforts to obtain timely and
47 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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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/>

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

22
23 Similarly, while there are some positive examples with PDMP-EHR integration, EHRs are
24 generally not interoperable between different organizations, making coordination between primary
25 care physicians, pain medicine physicians, addiction medicine physicians and other providers much
26 more difficult. When PDMP and EHR integration does exist (e.g., Oregon's EDIE), the patient,
27 public health and cost utilization benefits are extremely positive.¹² This integration requires time
28 and broad, institutional support. For example, the state of Washington's integration project with the
29 state Health Information Exchange (HIE) began in 2012. As of August 2017, more than 90 percent
30 of emergency departments include PDMP data in the EHR using data through the HIE.¹³ The
31 state's major health systems still are working to accomplish this integration.

32
33 To help resolve some of these issues, the AMA advocates for consistent and sufficient
34 appropriations to support a state's ability to maintain and improve its PDMP, including broad state-
35 based grants to improve statewide HIEs and the ability to integrate HIE data into the EHR of
36 statewide emergency departments and other providers. The AMA also would support a U.S.
37 Government Accountability Office study on best practices for small and large physician practices
38 on using PDMPs to improve pain care as well as treatment for substance use disorders. This would
39 include identifying how PDMPs can distinguish uncoordinated care from misuse or "doctor
40 shopping" as well as help coordinate care for a patient with a substance use disorder or other
41 condition requiring specialty care. In addition, a need exists to evaluate the variations in state-based
42 PDMP technology and work with the health IT industry to discuss "common understanding" of
43 how each PDMP works—providing transparency for EHR vendors to facilitate development of
44 custom connections between their products and PDMP software. This could include funding for
45 programs that pilot test low-cost technologies to better integrate EHRs and PDMPs as well as
46 efforts to identify burdensome federal regulations that prevent EHRs from being designed and
47 developed to support objective clinical decision-making.

48
49
50 The AMA also has been engaged in the SMART project to help EHR systems work better for
51 physicians and patients. A key component of this effort is the development of a flexible

1 information infrastructure that allows for free, open development of plug and play applications
2 (apps) to increase interoperability among health care technologies, including EHRs, in a more cost-
3 effective way. The infrastructure development specific to PDMPs is part of both ongoing research
4 as well as work by states working to achieve more comprehensive data integration.¹⁴ In addition,
5 the Office of the National Coordinator for Health Information Technology has compiled multiple
6 sources and pilot examples for PDMP and EHR integration.¹⁵ The pilot examples, not surprisingly,
7 found that PDMPs were most helpful when they were integrated into physicians' workflow as well
8 as EHRs.

9

10 **AMA POLICY**

11

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

14

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

22

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

28

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

32

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

36

37 **RECOMMENDATIONS**

38

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

41

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

48

49 2. That our AMA urge EHR vendors to increase transparency of custom connections and costs for
50 physicians to integrate their products in their practice. (Directive to Take Action)

1 3. That our AMA support state-based pilot studies of best practices to integrate EHRs, EPSC 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

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- ⁴ <https://www.healthcareitnews.com/news/opioid-epidemic-unc-health-care-integrate-epic-ehr-states-pdmp>
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- ⁶ Additional efforts in the commercial market to better integrate PDMP use into clinical workflow and integrate with EHRs include PMP Gateway from Appris Health (<https://apprishealth.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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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

1 At the 2018 Annual Meeting of the House of Delegates (HOD), the third resolve of Resolution
2 225-A-18 was referred for report back at the 2018 Interim Meeting. Resolution 225-A-18,
3 sponsored by American Society of Clinical Oncology (ASCO), asked that our American Medical
4 Association (AMA):

5
6 (3) support discontinuing the use of the Disproportionate Share Hospital (DSH) adjustment as a
7 determining measure for 340B program eligibility;

8
9 The reference committee heard mixed testimony on this resolve. Testimony was offered that
10 additional research and analysis is needed to assess how to identify the DSH hospitals that should
11 not benefit from 340B program rebates and those that should. The reference committee
12 recommended adopting Resolves 1, 2, and 4, and referral of Resolve 3 for a report back at the 2018
13 Interim Meeting.

14 AMA POLICY

15
16 Our AMA has an extensive policy that supports increased pharmaceutical drug and biological
17 affordability and policies to ensure patient access to medically necessary prescription medication.
18 However, our AMA does not have specific policy concerning the 340B program other than the
19 HOD adopted resolves of Resolution 225-A-18 (Policy H-110.985, “340B Drug Discount
20 Program”). There is a policy related to rebates which provides that our AMA supports legislation to
21 require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the
22 price of a generic drug rises faster than inflation. (Policy H-110.987, “Pharmaceutical Cost”). Thus,
23 there is support for rebate programs to the extent such programs benefit underinsured patients and
24 patients living on low-incomes. Consistent with the foregoing, AMA policy provides support for
25 the subsidization of prescription drugs for Medicare patients based on means testing (Policy
26 H-330.902, “Subsidizing Prescription Drugs for Elderly Patients”). However, AMA policy also
27 includes support for economic assistance, including coupons (and other discounts), for patients,
28 whether they are enrolled in government health insurance programs, enrolled in commercial
29 insurance plans, or are uninsured (Policy H-125.977, “Non-Formulary Medication and the
30 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' (HHS) Health Resources and Services Administration (HRSA), requires pharmaceutical manufacturers to sell outpatient prescription medication at a discount to covered entities. Congress established the 340B program in order to produce savings for certain safety-net health care providers by allowing them to purchase outpatient drugs at these discounted prices.¹ The U.S. House of Representatives' report, accompanying the original legislation, stated that these savings would "enable [participating] entities to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."² Pharmaceutical manufacturers are required to enter into an agreement, called a pharmaceutical pricing agreement (PPA), with the HHS Secretary. Under the PPA, the manufacturer agrees to provide front-end discounts on covered outpatient prescription medication purchased by "covered entities."

14

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

33

34 DISCUSSION

35

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

44

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

1 There have also been a number of unintended consequences of the 340B program. A 2015 Avalere
2 study found that hospitals participating in the 340B program were more likely than non-340B
3 hospitals to acquire independent physician practices.¹⁰ These acquisitions create financial windfalls
4 for hospitals due to the 340B program yet do not necessarily improve affordability for patients.
5 Patient costs and resultant co-pays/co-insurance and deductibles for care in a hospital outpatient
6 department (HOPDs) can be higher than those in physician offices.¹¹ (In those instances, patient
7 care in HOPDs is more costly for health insurers too.) Furthermore, some 340B eligible hospitals
8 may have commercial contracts that pay substantially more than the Medicare rate for drugs,¹² so
9 the profit margin can be multiples of the cost of the drug. Patients may face a 20 percent
10 coinsurance on this higher amount. Yet, hospitals eligible for the 340B program obtain drugs at a
11 substantial discount. The 340B program does not require that the hospital pass the savings to
12 uninsured or underinsured low-income patients. To the extent that the hospital does not pass along
13 the savings, the combined payment by insurer and patient provides profit for the 340B hospital; the
14 additional volume generated when 340B hospitals acquire independent physician practices results
15 in even greater profits. There are also reports that hospital systems have acquired 340B program
16 eligible hospitals in order to purchase drugs for their suburban clinics utilizing the discounts even
17 though such clinics do not serve uninsured or underinsured low-income patients.
18

19 There have been several congressional hearings on the 340B program convened by the U.S.
20 Senate's Health, Education, Labor, and Pension (HELP) Committee as well as the U.S. House of
21 Representatives' Energy and Commerce (E&C) Committee. Testimony offered by the U.S.
22 Government Accountability Office (GAO),¹³ the HHS Office of the Inspector General (OIG),¹⁴ and
23 other witnesses included concerns with the 340B program's: (1) inadequate "patient" definition;
24 (2) eligibility criteria for covered entity; (3) oversight of covered entities and manufacturers; and
25 (4) oversight of the use of contract pharmacies. The lack of program data to assess the extent to
26 which 340B program covered entities are ensuring low-income patients benefit from the rebates
27 and the savings has particularly troubled policymakers and other stakeholders.
28

29 In addition to the hearings, over 17 federal bills have been introduced concerning the 340B
30 program in this Congress. A number of the bills would mandate reporting on care provided to low-
31 income individuals and would impose new eligibility requirements for certain categories of
32 covered entities. For example, in December 2017, Representative Larry Buschon (R-IN) introduced
33 H.R. 4710, Protecting Access for Underserved and Safety-net Entities Act (340B PAUSE Act). The
34 bill would impose a moratorium on registration for certain new 340B program hospitals and
35 associated sites. H.R. 4710 would also mandate data collection by covered entities including the
36 number and percentage of insured (by insurer) and uninsured individuals who are dispensed or
37 administered 340B program discounted drugs. In January 2018, Senator Bill Cassidy (R-LA)
38 introduced S. 2312, Helping Ensure Low-income Patients have Access to Care and Treatment Act
39 (HELP Act). The bill would impose a registration moratorium on new non-rural 340B program
40 covered entities and associated sites as well as new eligibility requirements for covered entities. It
41 would also require reports on the level of charity care provided by covered entities. Similarly, in
42 April 2018, Representative Earl Carter (R-GA) introduced H.R. 5598, 340B Optimization Act. The
43 bill would amend the Public Health Service Act to require certain disproportionate share hospital
44 covered entities under the 340B drug discount program submit to HHS reports on low-income
45 utilization rates of outpatient hospital services furnished by such entities.
46

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

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

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

11
12 While the report provides additional needed analysis and data, more information is needed
13 concerning the programs implementation and benefit to low income patients. To ensure the 340B
14 program covered entity criteria aligns with the goal of ensuring low income patients are able to
15 access affordable treatments, at least one national medical specialty society has recommended that
16 Congress establish new metrics that such entities must meet that are objective, universal, verifiable
17 and align program eligibility with the care provided by the covered entity to indigent and
18 underserved individuals. Consistent with the foregoing, alternative eligibility measures could be
19 calculated by analyzing the amount of charity care provided by hospitals in the outpatient setting.
20 Ultimately, eligibility should be designed to qualify entities based on the amount of care delivered
21 to underserved populations in outpatient settings. This would dovetail with new AMA policy to
22 work with policymakers to establish 340B program eligibility for all physician practices
23 demonstrating a commitment to serving low-income and underserved patients, new covered entity
24 criteria should promote participation by institutions and practices of all sizes in all settings. To
25 advance this goal, ASCO has convened an expert workgroup to develop recommendations for a
26 revised eligibility formula in order to appropriately capture the level of outpatient charity care
27 provided by hospitals, as well as standalone community practices. ASCO will provide
28 policymakers and other stakeholders with the recommendations during the current congressional
29 session.

30
31 CONCLUSION

32
33 The significant growth of the 340B program, particularly among DSH hospitals, should align with
34 newly adopted HOD policy concerning 340B program and related AMA policies. Specifically, the
35 program should promote access to affordable prescription drugs by low-income patients receiving
36 care from 340B program covered entities. In addition, our AMA should engage with national
37 medical specialty societies to leverage expertise and align recommendations to federal
38 policymakers.

39
40 RECOMMENDATIONS

41
42 In light of these considerations, your Board of Trustees recommends that the following
43 recommendations be adopted in lieu of the third resolve Resolution 225-A-18 and the remainder of
44 this report be filed:

45
46 1. That our American Medical Association support a revised 340B drug discount program
47 covered entity eligibility formula, which appropriately captures the level of outpatient charity
48 care provided by hospitals, as well as standalone community practices. (New HOD Policy)

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

Fiscal Note: Less than \$5000

REFERENCES

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

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

³ 42 U.S.C. § 256b(a)(4)(A)–(K))

⁴ Id.

⁵ Id.

⁶ Id.

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

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

⁹ Id.

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

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

¹² Physician-administered Drugs: Comparison of Payer Payment Methodologies, U.S. Government Accountability Office, August 2016, Available at <https://www.gao.gov/assets/680/678784.pdf>

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

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

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-I-18

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

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

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

1 INTRODUCTION

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

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

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

14 CURRENT AMA POLICY

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

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

1 BACKGROUND

2

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

12

13 *The National Instant Criminal Background Check System (NICS)*

14

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

25

26 *Prohibited Persons and Mental Health*

27

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

36

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

43

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

45

46 A formal commitment of a person to a mental institution by a court, board, commission, or
47 other lawful authority. The term includes a commitment to a mental institution involuntarily.
48 The term includes commitment for mental defectiveness or mental illness. It also includes
49 commitments for other reasons, such as for drug use. The term does not include a person in a
50 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

1 25 percent higher rate in the first three years post repeal than during the prior nine years.¹⁵ A study
2 conducted in large urban counties found that PTP laws were associated with a 14 percent reduction
3 in firearm homicides.¹⁶ PTP law enactment was associated with protective effects against firearm
4 suicides in Connecticut, and PTP repeal in Missouri was associated with increased risk of firearm
5 suicides.¹⁷

6

7 *Mental Health Reporting*

8

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

22

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

31

32 Relationship to NARIP Funding. NARIP funding has been provided to states to address these
33 barriers. In order to receive NARIP funding, states are required to have a “relief from disabilities
34 statute” whereby firearm purchasing rights can be restored to a person who had them removed
35 because of a mental health adjudication or involuntary commitment. Information on the level of
36 funding by state from FY 2009-2017, as well as promising practices for improved record reporting
37 to the NICS, are available on the Bureau of Justice Statistics website.²⁵ As of July 2015, there were
38 3.8 million state-submitted mental health records in the NICS.²⁶ Forty-three states have enacted
39 laws that require (32) or authorize (11) the reporting of mental health records to NICS. The largest
40 increase in reported mental health data from 2008 to 2015 occurred in states with a reporting
41 requirement.²⁷ Twenty of the 26 states with the largest increase in mental health data also received
42 NARIP funding.

43

44 HIPAA Considerations. In 2013 there was considerable focus on whether the Health Insurance
45 Portability and Accountability Act (HIPAA) or state privacy laws were an obstacle to the
46 submission of mental health records to NICS.²⁸ On January 4, 2016, the U.S. Department of Health
47 and Human Services modified HIPAA to expressly permit certain covered entities to disclose to the
48 NICS the identities of those individuals who, for mental health reasons, are prohibited by federal
49 law from having a firearm.²⁹ The final rule noted that creating a limited express permission in the
50 HIPAA Privacy Rule to use or disclose certain information relevant to the federal mental health
51 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.

1 RECOMMENDATIONS

2
3 The Board of Trustees recommends that the following recommendations be adopted in lieu of the
4 first and third resolves of Resolution 419-A-18 and the remainder of the report be filed.

5
6 1. That Policy H-145.996, "Firearm Availability" be amended by addition and deletion to read as
7 follows:

8
9 H-145.996 Firearm Availability

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

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

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

26
27 2. That Policy H-145.972, "Firearms and High-Risk Individuals" be reaffirmed.

28
29 Our AMA supports: (1) the establishment of laws allowing family members, intimate partners,
30 household members, and law enforcement personnel to petition a court for the removal of a
31 firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are
32 under domestic violence restraining orders, convicted of misdemeanor domestic violence
33 crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence
34 restraining orders to include dating partners; (4) requiring states to have protocols or processes
35 in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic
36 violence restraining orders and gun violence restraining orders to be entered into the National
37 Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the
38 existence of laws that allow for the removal of firearms from high-risk individuals. (Reaffirm
39 HOD Policy)

40
41 3. That our American Medical Association: (1) encourages the enactment of state laws requiring
42 the reporting of relevant mental health records, as defined by state and federal law, to the
43 National Instant Criminal Background Check System (NICS); (2) supports federal funding to
44 provide grants to states to improve NICS reporting; and (3) encourages states to automate the
45 reporting of mental health records to NICS to improve the quality and timeliness of the data.
46 (New HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

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¹⁸ P.L. 110-80, § 102-104, 301 (2007).

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²⁰ U.S. Government Accountability Office, Gun Control: Sharing Promising Practices and Assessing Incentives Could Better Position Justice to Assist States in Providing Records for Background Checks. Washington, D.C. July 2012.

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³⁰ U.S. Department of Health and Human Services, HIPAA Privacy Rule and the National Instant Criminal Background Check System (NICS). Available at <https://www.hhs.gov/hipaa/for-professionals/special-topics/nics/index.html>. Accessed August 3, 2018.

³¹ 34 CFR 99.36

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³³ Public Law No: 115-141.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(I-18)

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

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

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

1 Whereas, AMA Policy H-180.956, "Physician Privileges Application – Timely Review by
2 Managed Care," states Medicare, Medicaid, and managed care organizations should
3 retroactively compensate physicians for services rendered from the date of their credentialing;
4 and
5
6 Whereas, [HB 139](#) was successfully passed by the 2018 Virginia General Assembly and signed
7 into law by Governor Northam. This allows physicians who are waiting to be credentialed by a
8 health plan to see patients and retroactively receive payments if they are ultimately
9 credentialed; and
10
11 Whereas, Physicians awaiting credentialing could be reimbursed \$1000 per day during the
12 credentialing process (*Virginia Medical News* – Spring/Summer 2018); therefore be it
13
14 RESOLVED, That our American Medical Association develop model state legislation for
15 physicians being credentialed by a health plan to treat patients and retroactively receive
16 payments if they are ultimately credentialed. (Directive to Take Action)

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

Received: 08/28/18

RELEVANT AMA POLICY

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(I-18)

Introduced by: Pennsylvania

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

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

1 Whereas, The opioid-overdose epidemic has had a devastating impact throughout the United
2 States and currently claims about 115 lives per day (1); and
3
4 Whereas, The Centers for Disease Control and Prevention in August 2018 reported a record
5 72,000 overdose deaths in 2017 (2); and
6
7 Whereas, Medications for opioid use disorder can facilitate recovery and prevent deaths (3);
8 and
9
10 Whereas, Great Britain, Canada and Australia have successfully made methadone available by
11 prescription, enhancing access to this valuable therapy (1); and
12
13 Whereas, Limited experience in the United States over a 10-year period has demonstrated the
14 success of such a primary care approach for treatment of opioid use disorder (1); and
15
16 Whereas, In 2001, there was a six-month randomized controlled trial that supported the success
17 of such a primary care based approach (4, 5); and
18
19 Whereas, Enhancing the opportunity for primary care practices to prescribe methadone might
20 increase the availability of such treatment in non-urban populations who lack access to
21 methadone clinics; and
22
23 Whereas, AMA Policy H-95.957 supports the concept of "...properly trained practicing
24 physicians as an extension of organized methadone maintenance programs in the management
25 of those patients whose needs for allied services are minimal...."; therefore be it
26
27 RESOLVED, That our American Medical Association identify and work to remove those
28 administrative and/or legal barriers that hamper the ability of primary care providers to prescribe
29 methadone, through all appropriate legislative and/or regulatory means possible (Directive to
30 Take Action); and be it further
31
32 RESOLVED, That our AMA, working with other federation stakeholders, identify the appropriate
33 educational tools that would support primary care physicians to provide ongoing methadone
34 treatment for appropriate patients. (Directive to Take Action)

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

Received: 09/21/18

References:

- (1) Samet JH, Botticelli MB, and Bharel M. "Perspective. Methadone in Primary Care – One Small Step for Congress, One Giant Leap for Addiction Treatment. N Eng J Med 379:7-8, 5 July 2018.
- (2) <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>.
- (3) Sordo L et al. "Mortality Risk during and after opioid substitution treatment; systemic review and meta-analysis of cohort studies." BMJ 357:j1550, 2017.
- (4) Fiellin DA et al. "Methadone Maintenance in Primary Care. A Randomized Controlled Trial. JAMA 286:1724-1731, 10 Oct 2001.
- (5) Stein MD and Friedmann PD. "Editorial: Generalist Physicians and Addiction Care. From Turfing to Sharing the Turf." JAMA 286: 1764-1765, 10 Oct 2001.

RELEVANT AMA POLICY

Methadone Maintenance in Private Practice H-95.957

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

CSA Rep. 2 - I-94 Reaffirmed: CSA Rep. 12 and Append Res. 412, A-99 Reaffirmation I-00
Modified: CSAPH Rep. 1, A-10

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-18)

Introduced by: Resident and Fellow Section

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

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

1 Whereas, The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal
2 law designed to protect a subset of identifiable information known as Protected Health
3 Information (PHI) and in 2009 HIPAA was expanded and strengthened by the Health
4 Information Technology for Economic and Clinical Health Act (HITECH Act); and
5
6 Whereas, The AMA has guidelines that expect all institutions to provide retirement benefits; and
7
8 Whereas, All technologies designed to be HIPAA-compliant must adhere to two rules: the
9 'Standards for Privacy of Individually Identifiable Health Information' known as the Privacy Rule,
10 and the 'Security Standards for the Protection of Electronic Protected Health Information' known
11 as the Security Rule¹; and
12
13 Whereas, Baseline cell phone security, text messaging and telecommunication technologies are
14 lacking in necessary security measures to meet the standards for HIPAA-compliance^{2,3}; and
15
16 Whereas, There are an increasing number of HIPAA-compliant applications related to patient
17 health and communication with several versions of developer's guides for HIPAA-compliance
18 distributed online for several years; and
19
20 Whereas, Despite evidence from studies showing perceived improvement in provider
21 communication with HIPAA-compliant text messaging applications, more than 50% of residents
22 report routinely text messaging protected health information (PHI) in violation of HIPAA^{3,4};
23 therefore be it
24
25 RESOLVED, That our American Medical Association promote the development and use of
26 Health Insurance Portability and Accountability Act of 1996 (HIPAA) -compliant technologies for
27 text messaging, electronic mail and video conferencing. (New HOD Policy)

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

Received: 09/27/18

References:

- 1 <https://www.informationweek.com/healthcare/security-and-privacy/hipaa-compliance-what-every-developer-should-know/a/d-id/1297180>
- 2 <http://library.ahima.org/doc?oid=105342#.WbdYI9hOmEc>
- 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)

1 Whereas, The Association of American Medical Colleges predicts a physician shortage of more
2 than 100,000 doctors by the year 2030¹; and
3
4 Whereas, International Medical Graduates (IMGs) are more likely to practice in primary care
5 specialties than US medical graduates²; and
6
7 Whereas, Foreign-born IMGs were more likely to practice in rural underserved areas than US
8 born IMGs²; and
9
10 Whereas, The Educational Commission for Foreign Medical Graduates (ECFMG) sponsors
11 approximately 10,000 J-1 visas annually; and
12
13 Whereas, The ECFMG prohibits physicians with a J-1 visa from moonlighting based on the US
14 Code of Federal Regulations 22CFR62.16³, and subsequently prohibits physicians with J-1
15 visas privileges to bill for services rendered; and
16
17 Whereas, Providing physicians with a J-1 visa billing privileges and the ability to moonlight may
18 improve the access to care in certain areas; therefore be it
19
20 RESOLVED, That our American Medical Association advocate for changes to federal legislation
21 allowing physicians with a J-1 visa in fellowship training programs the ability to moonlight. (New
22 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.ecfmg.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)

1 Whereas, Our AMA has supported legalization of the Deferred Action for Early Childhood Arrival
2 (DACA) children brought to this country illegally by their parents; and
3
4 Whereas, Our AMA has supported reducing the backlog of granting of green cards for
5 permanent residency which sometimes has been delayed for several years. This delay leads to
6 their children turning 21 years of age and thus becoming illegal; and
7
8 Whereas, There are thousands of children who arrived in this country with their parents legally,
9 however once they turn 21 years of age they automatically become illegal. They are then called
10 DALCA (Deferred Action for Legal Childhood Arrival); and
11
12 Whereas, There are 80,000-100,000 children that fall into this category; and
13
14 Whereas, Many of these DALCA children are in medical schools or have already graduated
15 from U.S. medical schools, but are subject to deportation because they are considered illegals.
16 Many of these DALCA children have matched in residency programs but have been held back
17 due to their lack of proper legal status; and
18
19 Whereas, There is bipartisan support in Congress for these children which has not garnered
20 media headlines; therefore be it
21
22 RESOLVED, That our American Medical Association support legalization of the Deferred Action
23 for Legal Childhood Arrival (DALCA) (New HOD Policy); and be it further
24
25 RESOLVED, That our AMA work with the appropriate agencies to allow DALCA children to start
26 and finish medical school and/or residency training until these DALCA children have officially
27 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 and
16
17 Whereas, Affirmative action has shown to increase medical practice in underserved areas with
18 minority populations and providing better healthcare for various communities;¹⁰ and
19
20 Whereas, Several states that have instituted bans on affirmative action have experienced
21 subsequent decreases in college enrollment by minority students, completion of STEM degrees
22 by minority students, and representation of minority students among matriculating medical
23 school students;^{2,3,11,12} and
24
25 Whereas, In 1978, 2003, and 2016 the supreme court upheld affirmative action in the cases of
26 *Regents of the University of California v. Bakke*, *Grutter v. Bollinger*, and *Fisher v. The*
27 *University of Texas at Austin*, respectively, allowing race to be one of several factors in college
28 admission policy;¹³⁻¹⁵ and
29
30 Whereas, Although AMA policy establishes a significant precedent to support undergraduate
31 education as a means to produce medical school matriculants (H-60.917, H-350.979,
32 H-200.985), existing policy falls short of addressing the necessity of affirmative action as
33 mechanism for equality at the undergraduate level, which is necessary to bolster the pool of
34 minority students able to apply to a medical program; and
35
36 Whereas, The Department of Justice has announced the intent to investigate and potentially
37 sue institutions utilizing affirmative action, threatening the principles of racial equality in
38 education that our AMA supports;¹⁶ therefore be it
39

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

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RELEVANT AMA POLICY

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

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

Citation: Res. 910, I-16

Equal Opportunity H-65.968

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

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

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

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

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

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(I-18)

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

Subject: Increasing Access to Broadband Internet to Reduce Health Disparities

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

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

4
5 Whereas, Residents of rural areas in the United States tend to be older and sicker than their
6 urban counterparts with higher rates of poverty, less access to healthcare, and higher likelihood
7 of dying from 5 leading causes of death when compared to their urban counterparts; and

8
9 Whereas, 23 million Americans live in areas that do not have broadband internet access; and

10
11 Whereas, Broadband internet provides access to resources not only for health care but also for
12 economic growth and job opportunities, educational opportunities, and government services;
13 and

14
15 Whereas, Our AMA has a broad swath of policies which encourage the use of, and pay for,
16 telemedicine, which requires broadband internet; and

17
18 Whereas, The Federal Communications Commission Connect2Health Task Force is currently
19 exploring the intersections of health and technology in rural areas; therefore be it

20
21 RESOLVED, That our American Medical Association advocate for the expansion of broadband
22 connectivity to all rural areas of the United States. (New HOD Policy)

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

Received: 09/28/18

RELEVANT AMA POLICY

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

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

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

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

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

Citation: BOT Rep. 39, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(I-18)

Introduced by: Women Physicians Section

Subject: Sexual Assault Education and Prevention in Public Schools

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

1 Whereas, Although the AMA has existing policy on the education and prevention of sexual
2 assault on college campuses, many adolescents have become victims of sexual assault and
3 AMA policy does not explicitly address this topic for this age group; and
4
5 Whereas, More than forty-two percent (42.2%) of forced sexual violence victims are assaulted
6 before they are 18 years old¹; and
7
8 Whereas, More than eleven percent (11.3%) of female high school students and 3.5% of male
9 high school students responding to the 2017 National Youth Risk Behavior Survey reported
10 victimization by forced sex²; and
11
12 Whereas, The 2017 National Youth Risk Behavior Survey also notes the incidence of forced sex
13 has failed to improve over the last decade among high school students²; and
14
15 Whereas, A significantly higher percentage of female students (10.7%) reported this sexual
16 dating violence in the past year compared to male students (2.8%)²; and
17
18 Whereas, Both forced sex and sexual dating violence disproportionately affects sexual
19 minorities in high school with 21.9% of lesbian, gay, or bisexual youth reporting forced sex
20 (compared to 5.4% of heterosexual youth)²; and
21
22 Whereas, At least two states (California and Missouri) require education of high school students
23 regarding consent as part of a mandate to teach about healthy relationships, and several others
24 have recently considered such legislation as the majority of U.S. teens may graduate high
25 school without any formal instruction on consent⁴⁻⁶; therefore be it
26
27 RESOLVED, That our American Medical Association support state legislation mandating that
28 public middle and high school health education programs include age appropriate information
29 on sexual assault education and prevention, including but not limited to topics of consent and
30 sexual bullying. (Directive to Take Action)

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

Received: 09/28/18

References:

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

- (i) about the donation procedure and possible risks and complications for the donor;
- (ii) about the possible risks and complications for the transplant recipient;
- (iii) about the nature of the commitment the donor is making and the implications for other parties;
- (iv) that the prospective donor may withdraw at any time before undergoing the intervention to remove the organ or collect tissue, whether the context is paired, domino, or chain donation; and
- (v) that if the donor withdraws, the health care team will report simply that the individual was not a suitable candidate for donation.

(j) Obtain the prospective donor's separate consent for donation and for the specific intervention(s) to remove the organ or collect tissue.

(k) Ensure that living donors do not receive payment of any kind for any of their solid organs. Donors should be compensated fairly for the expenses of travel, lodging, meals, lost wages, and medical care associated with the donation only.

(l) Permit living donors to designate a recipient, whether related to the donor or not.

(m) Decline to facilitate a living donation to a known recipient if the transplantation cannot reasonably be expected to yield the intended clinical benefit or achieve agreed on goals for the intended recipient.

(n) Permit living donors to designate a stranger as the intended recipient if doing so produces a net gain in the organ pool without unreasonably disadvantaging others on the waiting list. Variations on donation to a stranger include:

- (i) prospective donors who respond to public solicitations for organs or who wish to participate in a paired donation ("organ swap," as when donor-recipient pairs Y and Z with incompatible blood types are recombined to make compatible pairs: donor-Y with recipient-Z and donor-Z with recipient-Y);
- (ii) domino paired donation;
- (iii) nonsimultaneous extended altruistic donation ("chain donation").

(o) When the living donor does not designate a recipient, allocate organs according to the algorithm that governs the distribution of deceased donor organs.

(p) Protect the privacy and confidentiality of donors and recipients, which may be difficult in novel donation arrangements that involve many patients and in which donation-transplant cycles may be extended over time (as in domino or chain donation).

(q) Monitor prospective donors and recipients in proposed nontraditional donation arrangements for signs of psychological distress during screening and after the transplant is complete.

(r) Support the development and maintenance of a national database of living donor outcomes to support better understanding of associated harms and benefits and enhance the safety of living donation.

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

Issued: 2016

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)

1 Whereas, 1,981 people were injured and 590 people were killed during mass shootings in
2 2017;¹ and

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

8
9 Whereas, The contagion effect was previously demonstrated in suicides in the mid-1990s and
10 led to the development of media coverage guidelines by the CDC and more recently by the
11 WHO;^{4,5,6} and

12
13 Whereas, Multiple media organizations, including Associated Press Managing Editors and the
14 National Press Photographers Association, have contributed to the publication and adherence
15 of reporting guidelines for suicide that largely reflect the CDC's published guidelines;^{7,8} and

16
17
18 Whereas, Appropriate media coverage of suicide may lead to a reduction in suicide rates, an
19 effect known as the Papageno effect;⁹⁻¹² and

20
21 Whereas, Analysis of media coverage of mass shootings followed by copycat incidents of mass
22 shootings indicate a media contagion effect;^{2,3,9,13} therefore be it

23
24 RESOLVED, That our American Medical Association encourage the Centers for Disease
25 Control and Prevention, the National Institute of Mental Health, the Associated Press Managing
26 Editors, the National Press Photographers Association, and other relevant organizations to
27 develop guidelines for media coverage of mass shootings in a manner that is unlikely to provoke
28 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)

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

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

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

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

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

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

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

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

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

34 Whereas, The U.S. General Accounting Office estimates 31% of accidental firearm deaths
35 might be prevented by the addition of a child-proof safety lock (8%) and a loading indicator
36 (23%), which indicates whether a firearm is loaded and if it still contains rounds in the chamber;⁹
37 and

1 Whereas, The AAP's Council on Injury, Violence, and Poison Prevention recommends safe
2 storage and firearm safety features (i.e. trigger locks, lock boxes, gun safes) and supports the
3 funding of research related to the prevention of firearm injury;⁷ and
4
5 Whereas, The California Department of Justice declared any center-fire semi-automatic pistol to
6 be an "unsafe handgun" if it does not have a chamber load indicator or a magazine disconnect
7 mechanism;¹¹ and
8
9 Whereas, Research spending on firearm injuries conducted by the CDC fell by 96% from 1996
10 to 2012;¹² and
11
12 Whereas, A study concluded that between 2004 and 2015, research on national firearm
13 violence was significantly underfunded and understudied relative to other leading causes of
14 death, receiving less than 1.6% of the \$1.4 billion researchers predicted should be allocated to
15 study a public health issue with a similar number of deaths annually;¹³ and
16
17 Whereas, Existing AMA policy H-145.979 supports legislation that holds firearm owners legally
18 responsible for injury or death caused by a child gaining access to a firearm;¹⁴ and
19
20 Whereas, Child Access Prevention (CAP) laws, which encourage firearm owners to be
21 conscious of how they store their firearms, may be more preventive than AMA policy because
22 they range from strict laws that hold gun owners criminally liable when a child could likely gain
23 access to their gun to more lenient forms that only hold gun owners criminally liable if a child
24 actually obtains or uses the gun;¹⁵ and
25
26 Whereas, CAP laws are currently active in twenty-seven states as well as Washington D.C.;¹⁶
27 and
28
29 Whereas, Most states that enacted CAP laws experienced greater declines in the rate of
30 unintentional firearm deaths for children ages 0 to 14 compared with states not enacting the
31 laws;¹⁷ and
32
33 Whereas, Only states with felony prosecution for violation of CAP laws had statistically
34 significant declines in unintentional firearm deaths when adjusted for firearm prevalence;¹⁷ and
35
36 Whereas, when CAP laws were implemented, self-inflicted firearm injuries fell by 64% for youth
37 ages 18 and under, but did not decrease for adults based on data from the Agency for
38 Healthcare Research and Quality's Nationwide Inpatient Sample (NIS);¹⁸ therefore be it
39
40 RESOLVED, That our American Medical Association advocate for enactment of Child Access
41 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.