



2017 AMA Medical Student Section Annual Meeting Agenda Book

39th Annual Meeting | Hyatt Regency Chicago | June 8–10



June 2017

On behalf of the American Medical Association Medical Student Section (AMA-MSS) Governing Council, we welcome you to the 2017 AMA Medical Student Section Annual Meeting at the Hyatt Regency Chicago from Thursday, June 8, to Saturday, June 10.

This meeting is a time for medical students from around the country to network and participate in shaping the future of health care. In this rapidly changing era of medicine, success as a physician will require more than a mastery of the science learned in a lecture hall. Students will learn practical skills for leadership, advocacy, health policy analysis, community service, and career networking during the meeting.

Please take the time to review the official 2017 AMA Medical Student Section Annual Meeting Agenda Book, which includes everything you will need in order to participate in all of the exciting education programs, volunteer opportunities, and networking events we have planned. The complete Agenda Book is available on the [AMA Medical Student Section Meeting Resources webpage](#). Please download the Agenda Book in its entirety prior to the meeting; printed copies will not be available. Make sure to bring your laptops; we will be providing internet access to delegates, as well as extra outlets for charging. Also, be sure to like us on Facebook for AMA-MSS updates throughout the year: <https://www.facebook.com/AMAmestudents/>.

Additionally, we would like to highlight the following items for this Interim meeting:

Keynote Presentations

- Susan E. Skochelak, MD, MPH, Group Vice President, Medical Education: Accelerating Change in Medical Education Update
 - Friday, June 9 at 2:30pm | Regency Ballroom A-C (West Tower)
- Andrew W. Gurman, MD, President, AMA: Address to MSS Assembly
 - Saturday, June 10 at 9:30am | Regency Ballroom A-C

Orientation for AMA-MSS Opportunities/First-Time Attendees

Is this your first AMA Medical Student Section Meeting? Then you won't want to miss the Orientation! Here you will learn about the AMA, how medical students make an impact on a local and national level, what to expect at the meeting, resolution writing, and parliamentary procedure.

- Thursday, June 8 | 4:30-6:00pm | Acapulco (West Tower)

Volunteer opportunity in Chicago: [AMA Doctors Back to School™](#)

The AMA Minority Affairs Section (AMA-MAS) has arranged for an AMA Doctors Back to School™ visit on Friday morning, June 9 to Simeon High School in Chicago. Volunteer with other medical students and physicians to participate and meet students from underrepresented racial and ethnic groups and communicate how a career in medicine is attainable for everyone.

- Transportation will be provided. Meet in Hyatt East Tower lobby at 7:00am; return by 11:45am.
- Contact dbts@ama-assn.org for full itinerary. Remember to wear your scrubs!

Featured education programs

- **Narcan Training: Combatting the Opioid Epidemic**
 - Thursday, June 8 | 6:00–7:00pm | Acapulco
- **Evaluating and Communicating Innovative Ideas**
 - Friday, June 9 | 9:00–10:00am | Acapulco
- **Addressing intentional violence through a public health lens**
 - Friday, Jun 9 | 2:00–3:00pm | Acapulco

Networking opportunities

- **Mentoring Session with Women Physicians Section (WPS) Leaders**
 - Hosted by AMA Women Physician Section (AMA-WPS) and AMA Medical Student Section (AMA-MSS)
 - Friday, June 9 | 1:00–2:00pm | Acapulco
- **Networking Event: Medical Students with Resident & Fellows**
 - Hosted by AMA Resident and Fellow Section (AMA-RFS) and AMA Medical Student Section (AMA-MSS)
 - Friday, June 9 | 5:00–6:00pm | Toronto (West Tower)

AMA-MSS National Service Project in Chicago: Medication Take Back Day

It is common to have expired or unneeded medications in your home. These pose a safety risk, as they can easily fall into the wrong hands. However, simply throwing medications in the trash can threaten the environment. Together, the American Medical Association and the Metropolitan Water Reclamation District are hosting a medication take back event on Saturday, June 10 in Chicago. You can quickly drop off any unwanted medications, and they will be safely disposed of. See the [Facebook page](#) lead by the AMA-MSS Committee on Community Service for more information.

- Saturday, June 10 | 9:00am–12:00pm | Metropolitan Water Reclamation District of Greater Chicago Headquarter Building 100 E Erie St, Chicago, Illinois

AMA Medical Specialty Showcase & Clinical Skills Workshop

Discover more than 40 specialty societies and professional interest medical associations and receive career advice from physicians and residents at these organizations. Also, take the opportunity to gain hands-on instruction on essential medical skills such as airway management, ultrasound, splinting, suturing, proper blood pressure techniques and more from the AMA Clinical Skills Workshop. Enter the Sweepstakes by submitting an entry form at any of the exhibitor booths. Prizes include \$100 Hertz certificates, \$100 Amazon gift card, Health Systems Science textbook, gift sets from the AMA and JAMA, and **one free registration for the 2018 AMA Medical Student Advocacy and Region Conference.**

- Saturday, June 10 | 11:30am–1:30pm | Riverside Exhibit Hall (East Tower)

Dress code

Business casual is appropriate for the Meeting, including reference committee hearings. We do ask that business attire be worn by those seated on the days during the AMA House of Delegates business sessions. This includes reports of the reference committees.

Elections

The AMA-MSS Governing Council elections are scheduled for Saturday, June 10 at 7:30am and will begin promptly for Assembly to resume at 8:00am. Please carefully review the personal statements and curriculum vitae that the candidates have submitted for the Election Manual. In addition to these materials, there will be an informal Candidate Forum on Friday, June 9 at 7:30-

8:00am in Regency Ballroom A-C (West Tower) to meet the candidates running for the 2017-2018 AMA-MSS Governing Council.

Special Note for Satellite Campus Delegates/Alternate Delegates

Per MSS Policy 665.006, satellite campus Delegates and Alternate Delegates must provide proof of current satellite campus attendance in order to be credentialed as AMA-MSS Assembly Representatives. Acceptable forms of identification include a campus-specific identification card or a letter from a medical school dean or other school official certifying that the student does, in fact, attend the satellite campus in question. **Satellite campus representatives will not be credentialed without proof of satellite campus attendance.**

If you have any questions, comments, or suggestions to improve our MSS Assembly meetings, please feel free to contact us or any other MSS Governing Council member. We look forward to working with you in Chicago! Thank you for your commitment and participation.

Sincerely,



Hunter Pattison, MD
Speaker, Medical Student Section



Theresa Phan, MD, MPH
Vice Speaker, Medical Student Section

Get connected with the new AMA Meetings app

We're excited to announce the launch of our new mobile app to enhance the Annual Meeting experience. The app will be a vital resource center as well as a hub for networking opportunities with fellow attendees. Take advantage of this powerful tool to:

- Control privacy settings
- Build your schedule and export it to your calendar
- Find colleagues and text message fellow attendees
- Access reports, resolutions and Policy Finder
- Take notes and share photos from sessions
- Share #AMAmtg activity on Twitter and Facebook

AMA Meetings app basics

I have last year's mobile app "AMA Events" on my device. Can I still use it?

Our previous app ("AMA Events") is no longer supported and does not contain information for the 2016 Annual Meeting. Please delete this app from your device -- to avoid confusion -- and download our current mobile app, "AMA Meetings."

Where can I download the new mobile app?

The new "AMA Meetings" mobile app is available for iPhone and Android devices in Apple's App Store and the Google Play store. You can find the app in either store by searching for "AMA Meetings."



The app is asking me to log in. Why do I need to log-in?

Once you log in to the mobile app, you will be able to access the same schedules, bookmarks, reminders, notes, and contacts on your phone, tablet, and desktop.

Where can I get my log-in information?

The log-in process is largely self-managed. Follow the steps below to log in from your device:

- **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.
- **Enter your info:** You'll be prompted to enter your first and last name. Tap Next. Enter an email address, then tap Next again.
- **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.
-

I've requested log-in information, but I never received an email.

If you haven't received your log-in information, one likely culprit may be your spam filter. We try to tailor our email communications to avoid this filter, but some emails end up there anyway. Please first check the spam folder of your email client. The sender may be listed as CrowdCompass or AMA Meetings.

I lost my log-in info, and I forgot my confirmation code. How do I log myself back in?

To have a verification email resent to you, start by accessing the sign-in page.

- **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.
- **Enter your info:** You'll be prompted to enter your first and last name. Tap Next.
- **Click on Forgot Code:** If you've already logged in before, the app will already know your email address and will send a verification email to you again.
- **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

How do I create my own schedule?

- **Open the Schedule.** After logging in, tap the Schedule icon.
- **Browse the Calendar.** Switch days by using the date selector at the top of the screen. Scroll up and down to see all the sessions on a particular day.
- **See something interesting?** Tap the plus sign to the right of its name to add it to your personal schedule.

How can I export my schedule to my device's calendar?

- **Access your schedule.** After logging in, tap the hamburger icon in the top right, then My Schedule.
- Here you'll see a personalized calendar of the sessions you'll be attending. You can tap a session to see more details.
- **Export it.** Tap the download icon at the top right of the screen. A confirmation screen will appear. Tap Export and your schedule will be added directly to your device's calendar.

How do I allow notifications on my device?

Allowing Notifications on iOS:

- **Access the Notifications menu.** From the home screen of your phone, tap Settings, then Notifications.
- **Turn on Notifications for the app.** Find the AMA Meetings app on the list and tap its name. Switch Allow Notifications on.

Allowing Notifications on Android:

Note: Not all Android phones are the same. The directions below walk you through the most common OS, Android 5.0.

- **Access the Notification menu.** Swipe down on the home screen of your phone, then click the gear in the top right. Tap Sounds and notifications.
- **Turn on Notifications for the AMA Meetings app.** Scroll down and tap App notifications. Find the AMA Meetings app on the list. Switch notifications from off to on.

How do I manage my privacy within the app?

Set Your Profile to Private...

- **Access your profile settings.** If you'd rather have control over who can see your profile, you can set it to private.
- After logging in, tap the hamburger icon in the top left, then tap your name at the top of the screen.
- **Check the box.** At the top of your Profile Settings, make sure that the box next to "Set Profile to Private" is checked.

...Or Hide Your Profile Entirely

- **Access the Attendee List.** Rather focus on the conference? Log in, open the Event Directory, and tap the Attendees icon.
- **Change your Attendee Options.** Click the Silhouette icon in the top right to open Attendee Options.
- **Make sure the slider next to "Show Me On Attendee List" is switched off.** Fellow attendees will no longer be able to find you on the list at all.

How do I message other attendees within the app?

- **Access the Attendee List.** After logging in, tap the Attendees icon.
- **Send your message.** Find the person you want to message by either scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon to start texting.
- **Find previous chats.** If you want to pick up a chat you previously started, tap the hamburger icon in the top right, then **My Messages**.

How do I block a person from chatting with me?

- **Access the Attendee List.** Rather focus on the conference? Just as before, log in and tap the Attendees icon.
- **Block the person.** Find the person you'd like to block about by scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon. But, don't type anything, instead tap Block in the top right.

I want to network with other attendees. How do I share my contact info with them?

- **Access the Attendee List.** After logging in, tap the Attendees icon.
- **Send a request.** Find the person you want to share your contact information by either scrolling through the list or using the search bar at the top of the screen.
- Tap their name, then the plus icon to send a contact request. If they accept, the two of you will exchange info.

I want to schedule an appointment with other attendees. How do I do that?

- **Navigate to My Schedule.** Tap the hamburger icon in the top left, then My Schedule.
- **Create Your Appointment.** In the top right corner of the My Schedule page you'll see a plus sign. Tap on it to access the Add Activity page.
- **Give your appointment a name, a start and end time, and some invitees.** When you're finished, tap Done. Invitations will be immediately sent to all relevant attendees.

How do I take notes within the app?

Write Your Thoughts...

- **Find your Event Item.** After logging in, find the session, speaker, or attendee you'd like to create a note about by tapping on the appropriate icon in the Event Directory, then scrolling through the item list. Once you've found the item you're looking for, tap on it.
- **Write your note.** Tap the pencil icon to bring up a blank page and your keyboard. Enter your thoughts, observations, and ideas. Tap Done when you've finished.

...Then Export Them

- **Navigate to My Notes.** Tap the hamburger icon in the top right, then "My Notes. Here you'll find all the notes you've taken organized by session.
- **Choose where to send your notes.** Tap the share icon in the top right and the app generates a draft of an email that contains all your notes. Enter an email address, then tap Send.



2017 AMA Medical Student Section Annual Meeting Agenda

Hyatt Regency Chicago, Illinois

June 8–10

Registration 3:00–8:00pm | Grand Ballroom Foyer (East Tower)

Thursday, June 8			
	Policy Regency Ballroom A-C (West Tower)	Education	Networking and Events
3:00pm		Medical Student Advocacy & the AMA: A Professional Advocacy Workshop (3-4:30pm Acapulco) Presenters: Christopher Clifford, Govt Relations Adv Fellow (GRAF), AMA Debra Cohn, Division of Legislative Council, AMA Todd Askew, Director, Congressional Affairs, AMA	
4:30pm		Welcome to Annual 2017: Orientation (4:30-6pm Acapulco) Intro to AMA, Meet & Greet with AMA-MSS Governing Council, Parli Pro demonstration	
6:00pm		Narcan Training: Combatting the Opioid Epidemic (6-7pm Acapulco) Guest speaker: James Ahn, MD, FACEP, Asst Prof of Med; Director, Med Edu Fellowship; Assoc Director, Emer Med Residency Pgrm, Univ of Chi Med Ctr	
7:00pm	AMA-MSS Region Business Meetings (7-9pm) Region 1: Regency A-C (front) Region 2: Columbus E/F Region 3: Dusable Region 4: Toronto Region 5: Acapulco Region 6: Regency A-C (back) Region 7: Hong Kong		

Region 1

Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington (WWAMI), Wyoming

Region 2

Illinois, Iowa, Minnesota, Missouri, Nebraska, Wisconsin

Region 3

Arkansas, Kansas, Louisiana, Mississippi, Oklahoma, Texas

Region 4

Alabama, Florida, Georgia, North Carolina, Puerto Rico, South Carolina, Tennessee

Region 5

Indiana, Kentucky, Michigan, Ohio, West Virginia

Region 6

Delaware, District of Columbia, New Jersey, Maryland, Pennsylvania, Virginia

Region 7

Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont

Registration 7:00am–5:00pm | Grand Ballroom Foyer (East Tower)

Friday, June 9			
	Policy Regency Ballroom A-C (West Tower)	Education	Networking and Events
7:00am	Breakfast Delegate Credentialing (7-7:30am)		AMA Doctors Back to School™ visit Meet in Hyatt East Tower Lobby at 7:30am; return by 11:45am Transportation provided Location: Simeon High School Contact dbts@ama-assn.org for full itinerary
7:30am	Candidate Forum (7:30-8am)		
8:00am	AMA-MSS Opening Assembly (8-10am) Christopher Libby, MD, MPH, AMA-MSS Chair address, Omar Maniya, MD, MBA, AMA Board of Trustees Student Member Update Nominations, Candidate speeches, Extractions		
9:00am		Evaluating and Communicating Innovative Ideas (9-10am Acapulco) Presenters: Joe Nellis, Univ of Iowa Carver COM; Cornell Univ Johnson Grad Schl of Mgmt Seth Aschen, Weill Cornell Med Coll; Cornell Univ Johnson Grad Schl of Mgmt Jack Fitzgibbons, Univ of Chi Booth Schl of Business	
10:00am	AMA-MSS Region Policy Meetings (10am-12pm) Region 1: Hong Kong Region 2: Grand Ballroom B Region 3: New Orleans Region 4: Regency A-C (back)	Bringing a Medical Device from Bench to Bedside (10-11am Acapulco) Guest speaker: Donald Eckhoff, MD, MS, Prof, Dept of Orthopaedics, Univ of Colorado SOM	
11:00am	Region 5: Plaza B Region 6: Gold Coast Region 7: Regency A-C (front)	Stem Cells and Regenerative Medicine (11am-12pm Acapulco)	
12:00pm			How to recruit new members & engage your new and existing student members (12-1pm Hong Kong) Guest speaker: Robert Wah, MD, Global Chief Medical Officer, DXC Technology; Former President, American Medical Association (2014-2015)
12:30pm	Delegate Credentialing (12:30-1pm)		
1:00pm	AMA-MSS General Assembly (1-5pm) Susan E. Skochelak, MD, MPH, Group Vice President, Medical Education, AMA; ACE Update, 2:30pm Voting on MSS Reference Committee Report	Mentoring Session with Women Physicians Section (WPS) Leaders (1-2pm Acapulco) AMA-WPS GC Guest speakers: Christina Talerico, MD Lynda Kabbash, MD Kusum Punjabi, MD, MBA Poornima Oruganti, MD, MPH Josephine Nguyen, MD Alice Coombs, MD Neelum Aggarwal, MD Ami Shah, MD	
2:00pm		Addressing intentional violence through a public health lens (2-3pm Acapulco) Guest speaker: Selwyn Rogers, MD, MPH, Med Director, Prof, Trauma and Acute Care Surgery, Univ of Chi Med; Exec VP, Community Health Engagement, Univ of Chi Med	Introduction to Osteopathic Manipulative Management (OMM) (2-3pm Columbus E/F) Guest speaker: Laura M. Rosch, DO, FACOI, CS, Chair, Dept of Internal Med, Chi Coll of Osteopathic Med Midwestern Univ
3:00pm		Healthcare Delivery in Hostile Conflict Zones (3-4pm Acapulco) Guest speakers: Muffadel Hamadeh, MD, Board Member, Syrian American Medical Society; Mahmoud Hariri, MD, Senior Research Fellow, Harvard Humanitarian Initiative	
4:00pm		Women's Occupational Health (4-5pm Acapulco)	Accelerating Change in Medical Education (ACE) Consortium: Building the Medical School of the Future (4-5pm Columbus E/F) Guest speakers: George C. Mejjicano, MD, MS, Prof of Med, Div of Infectious Diseases, Oregon Health & Science Univ Vineet Arora, MD, MAPP, The University of Chi Med
5:00pm		Mental Health Matters (5-6pm Acapulco) Guest speaker: Joshua Nathan, MD, FAPA, Asst Prof of Clinical Psychiatry; Director, Mood and Anxiety Disorders Pgrm	Medical Student and Resident & Fellow Networking Event (5-6pm Toronto)

Friday, June 9 continued

6:00pm	AMA-MSS Region Business Meetings (6-8pm) Region 1: Regency A-C (front) Region 2: Acapulco Region 3: Regency A-C (back) Region 4: Gold Coast Region 5: Columbus E/F Region 6: Toronto Region 7: Comiskey	
8:00pm	Newly Elected Region Leadership Orientation (8-8:30pm Regency Ballroom A-C (back))	

Registration 7:00–10:00am | Grand Ballroom Foyer (East Tower)

Saturday, June 10

	Policy Regency Ballroom A-C (West Tower)	Education	Networking and Events
7:00am	Breakfast Delegate Credentialing (7:00-7:30am)		AMA-MSS National Service Project: Medication Take Back Day (9am-12pm Metropolitan Water Reclamation District of Greater Chicago Headquarter Building)
7:30am	Elections (7:30-8am)		
8:00am	AMA-MSS General Assembly (8-11:30am) Hans Arora, MD, PhD, AMA-RFS Chair address, 8:30am Andrew W. Gurman, MD, President, AMA Address to MSS Assembly, 9:30am	The Gender Revolution: Caring for the Transgender Patient (8:30-9:30am Hong Kong) Guest speaker: Jesse M. Ehrenfeld, MD, MPH, Member, Board of Trustees, AMA; Assoc Prof of Anesthesiology, Surgery, Biomed Informatics & Health Policy, Vanderbilt Univ SOM	
8:30am			
9:30am		How to Impress on Wards (9:30-10:30am Hong Kong) Guest speaker: Mark Hill, MD, FACS, Prof of Surgery, The Chi Med School	Forum on the intersectionality of minority and LGBTQ health (10am-12pm Randolph 3)
10:00am		How to Read an Insurance Card (10:30-11:30am Hong Kong)	
10:30am			
11:30am		AMA Medical Specialty Showcase & Clinical Skills Workshop (11:30am-1:30pm Riverside Exhibit Hall - East Tower)	



2017 AMA Medical Student Section Annual Meeting

Hyatt Regency Chicago, Illinois

June 8-10

Descriptions of education programs, volunteer opportunities, and networking events

Thursday, June 8

Medical Student Advocacy & the AMA: A Professional Advocacy Workshop

AMA-MSS Committee on Legislation & Advocacy

3:00–4:30pm | Acapulco (West Tower)

This workshop aims to provide medical students with training on how to advocate for their profession and their patients, current and future, effectively. Students will learn techniques to share an advocacy message with legislators, to campaign for a position, and to give targeted speeches at their AMA sections (e.g. on GME, residency interviews, and more). Students will have the opportunity to hear from AMA experts, as well as peers, on how to hone these skills.

Presenters: Christopher Clifford, Government Relations Advocacy Fellow (GRAF), AMA | Debra Cohn, Division of Legislative Council, AMA | Todd Askew, Director, Congressional Affairs, AMA

Welcome to Annual 2017: Orientation

AMA-MSS Governing Council

4:30–6:00pm | Acapulco (West Tower)

Learn about everything the AMA National Medical Student Annual Meeting has to offer! Hear from your AMA Medical Student Section (AMA-MSS) Governing Council about how to get the most out of your national AMA medical student conference and learn about additional leadership opportunities within our Section.

Presenters: Hunter Pattison, MD, AMA-MSS Speaker | Theresa Phan, MD, MPH, AMA-MSS Vice Speaker

Narcan Training: Combatting the Opioid Epidemic

AMA-MSS Committee on Legislation & Advocacy

6:00–7:00pm | Acapulco (West Tower)

Join the Committee on Legislation & Advocacy as we explore our country's opioid epidemic. Become a more effective first responder as you learn how to recognize an opioid overdose and are trained to use Naloxone, the reversal drug for opioid overdose. This workshop will focus on the education and destigmatization of substance use disorders as well as a discussion on the current medical and political strategies being utilized to combat the opioid epidemic.

Guest speaker: James Ahn, MD, FACEP, Assistant Professor of Medicine; Director, Medical Education Fellowship; Associate Director, Emergency Medicine Residency Program, University of Chicago Medical Center

Friday, June 9

Volunteer opportunity in Chicago: [AMA Doctors Back to School™](#)

The AMA Minority Affairs Section (AMA-MAS) has arranged for an AMA Doctors Back to School™ visit on Friday morning, June 9 to Simeon High School in Chicago. Volunteer with other medical students and physicians to participate and meet students from underrepresented racial and ethnic groups and communicate how a career in medicine is attainable for everyone.

- Transportation will be provided. Meet in Hyatt East Tower lobby at 7:00am; return by 11:45am.
- Contact dbts@ama-assn.org for full itinerary. Remember to wear your scrubs!

Delegate Credentialing | Breakfast

7:00–7:30am | Regency Ballroom A-C (West Tower)

Registered delegates must pick up their voting badges at the back of the Ballroom.

Candidate Forum

7:30–8:00am | Regency Ballroom A-C (West Tower)

Take an opportunity to interact with the medical student candidates running for your 2017-2018 AMA-MSS Governing Council.

Evaluating and Communicating Innovative Ideas

9:00–10:00am | Acapulco (West Tower)

During this program you will be provided with a framework for critically evaluating innovative medical ideas through customer discovery, the business model canvas, and the approach investors take to quickly assess your idea. Further, you will gain a perspective on how to communicate your innovative medical ideas through various stakeholders, including those without medical backgrounds.

Presenters: Joe Nellis, University of Iowa Carver College of Medicine, Cornell University Johnson Graduate School of Management | Seth Aschen, Weill Cornell Medical College, Cornell University Johnson Graduate School of Management | Jack Fitzgibbons, University of Chicago Booth School of Business

Bringing a Medical Device from Bench to Bedside

AMA-MSS Committee on Scientific Issues

10:00–11:00am | Acapulco (West Tower)

Medical devices are used frequently in patient care and will continue to play an important role in the future of medicine. These instruments can aid in the diagnosis, treatment, management, and alleviation of disease. This program will focus on commonly used medical devices in a variety of different medical specialties, as well as a focus on clinical trials and the process of bringing a medical device from bench to bedside.

Guest speaker: Donald Eckhoff, MD, MS, Professor, Department of Orthopaedics, University of Colorado School of Medicine

Stem Cells and Regenerative Medicine

AMA-MSS Committee on Scientific Issues

11:00am–12:00pm | Acapulco (West Tower)

Stem cells are dedifferentiated cells that have the ability to change into specialized cell types. This program offers an opportunity to explore the different types of stem cells: including embryonic, adult, and induced

pluripotent stem cells, as well as a focus on current uses of stem cells (bone marrow transplants) and potential areas for use of stem cells in tissue engineering and regenerative medicine.

How to recruit new members & engage your new and existing student members

AMA-MSS Committee on Membership, Engagement, and Recruitment

12:00–1:00pm | Hong Kong (West Tower)

Learn about practical skills as well as the available resources to recruit new medical student members at your respective medical school. We will also help you create an engagement plan to engage new and existing members. We will also break out into groups lead by students on the Membership, Engagement and Recruitment Committee to discuss and brainstorm event tactics that will work best on campus. Upon completion you will be able to identify and plan events that will bring excitement and value to your campus this fall!

Note: This session is required for all Medical Student Outreach Leaders attending Annual.

Guest speaker: Robert Wah, MD, Global Chief Medical Officer, DXC Technology; Former President, American Medical Association (2014-2015)

Mentoring Session with Women Physicians Section (WPS) Leaders

AMA Women Physician Section (AMA-WPS) and AMA Medical Student Section (AMA-MSS)

1:00–2:00pm | Acapulco (West Tower)

Mentors can help inspire the next generation of physicians! For female medical students, having a woman physician who serves as a mentor may be one of the most valuable resources on the path to becoming a physician. The AMA Women Physicians Section (AMA-WPS) Governing Council will hold breakout discussions on seven topics of interest to students: choosing a residency, communicating with patients, dual degree physicians, developing leadership skills as a physician leader, critical decision making in leadership, careers in academic medicine, and contract negotiation.

AMA-WPS GC Guest speakers: Christina Talerico, MD | Lynda Kabbash, MD | Kusum Punjabi, MD, MBA | Poornima Oruganti, MD, MPH | Josephine Nguyen, MD | Alice Coombs, MD | Neelum Aggarwal, MD | Ami Shah, MD

Addressing intentional violence through a public health lens

AMA-MSS Committee on Minority Issues

2:00–3:00pm | Acapulco (West Tower)

In this program, violence is introduced as a public health issue and the models we use to prevent it, such as hospital-based recovery programs. Trauma will also be discussed as a social determinant of health, seeking to understand the environmental context from which it arises.

Guest speaker: Selwyn Rogers, MD, MPH, Medical Director, Professor, Trauma and Acute Care Surgery, University of Chicago Medicine; Executive Vice President, Community Health Engagement, University of Chicago Medicine

Introduction to Osteopathic Manipulative Management (OMM)

AMA-MSS Committee on Global and Public Health

2:00–3:00pm | Columbus E/F (East Tower)

Guest speaker: Laura M. Rosch, DO, FACOI, CS, Chair, Department of Internal Medicine, Chicago College of Osteopathic Medicine Midwestern University

Healthcare Delivery in Hostile Conflict Zones

AMA-MSS Committee on Global and Public Health

3:00–4:00pm | Acapulco (West Tower)

Join us to learn about healthcare delivery in conflict and disaster zones, such as Iraq, Syria, and Sudan. We will explore the role of physicians in these situations, current legislation in the US, social determinants of health on refugees outcomes, how to tailor care for this subset of individuals, and the public health implications in these crises. By learning more about health infrastructure, economics, and epidemiology, you'll learn more about how to effectively provide healthcare for individuals afflicted by crisis.

Guest speakers: Muffadel Hamadeh, MD, Board Member, Syrian American Medical Society | Mahmoud Hariri, MD, Senior Research Fellow, Harvard Humanitarian Initiative

Women's Occupational Health

AMA-MSS Committee on Global and Public Health and AMA Women Physician Section (AMA-WPS)

4:00–5:00pm | Acapulco (West Tower)

Achieving gender equality is a common goal shared by local and global leaders across multiple fields, ranging from science and technology to the corporate sector to the arts. When it comes to the workplace, discussions of gender equality often touch on topics such as participation, pay, and leadership. But did you know that gender influence at the workplace can also affect health outcomes? Join us as we explore how one's occupation can influence one's health, and how gender-based variables shape these outcomes. Learn through group-based cases that explore the intersection of occupation, gender, race, and more – as well as how advocating for gender equality is advocating for health equality!

Accelerating Change in Medical Education (ACE) Consortium: Building the Medical School of the Future

AMA-MSS Committee on Medical Education

4:00–5:00pm | Columbus E/F (East Tower)

This program session is aimed at providing an introduction into some of the innovative and exciting changes at AMA grant recipient schools. Guest speakers will also be available for students to get more detailed questions answered on how the AMA's consortium schools are changing the way medical schools educate future physicians.

Guest speakers: George C. Mejjicano, MD, MS, Professor of Medicine, Division of Infectious Diseases, Oregon Health & Science University | Vineet Arora, MD, MAPP, The University of Chicago Medicine

Mental Health Matters

AMA-MSS Committee on Bioethics and Humanities

5:00–6:00pm | Acapulco (West Tower)

In December, JAMA reported that more than ¼ of medical students suffer from depression and over 1/10 have suicidal ideation. The demands of medical education, and the stigma attached to mental health disorders, prevent many students from seeking help. The mental health concerns faced by medical students have the potential to follow them throughout their careers; therefore, understanding and managing these problems early on may help prevent tragedy. Our programming session will be focused on making students aware of the scope of the problem, equipping them with the tools and resources to prevent and manage mental health concerns, and encouraging them to advocate for themselves and their peers.

Guest speaker: Joshua Nathan, MD, FAPA, Assistant Professor of Clinical Psychiatry, Director, Mood and Anxiety Disorders Program

Medical Student and Resident & Fellow Networking Event

AMA Resident and Fellow Section (AMA-RFS) and AMA Medical Student Section (AMA-MSS)

5:00–6:00pm | Toronto (West Tower)

The AMA Resident and Fellow Section has agreed to take time on Friday evening to offer an opportunity for medical students to network with residents and fellows in attendance at the Annual Meeting. Come meet other members of the AMA who were just medical students like you not too long ago and ask questions about their specialties and life after medical school!

Saturday, June 10

Delegate Credentialing | Breakfast

7:00–7:30am | Regency Ballroom A-C (West Tower)

Registered delegates must pick up their voting badges at the back of the Ballroom.

Elections

7:30–8:00am | Regency Ballroom A-C (West Tower)

Election voting opens promptly at 7:30am and will close **sharply at 8:00am**.

The Gender Revolution: Caring for the Transgender Patient

AMA-MSS Committee on Minority Issues

8:30–9:30am | Hong Kong (West Tower)

Even with a “revolution” of medical and scientific knowledge regarding gender and sexual identity, the healthcare needs of transgender patients are often neglected even by the most competent physicians. This gap in care is often related to lack of education on how to approach transgender patients’ health needs and how to provide appropriate and sensitive care. Therefore, the gender revolution must begin with us as physicians. Please attend this interactive session to obtain a basic vocabulary for caring for transgender patients and to discuss their unique needs, how you as a provider can meet those needs, and what obstacles still exist toward meeting these needs.

Guest speaker: Jesse M. Ehrenfeld, MD, MPH, Member, Board of Trustees, AMA; Associate Professor of Anesthesiology, Surgery, Biomedical Informatics & Health Policy, Vanderbilt University School of Medicine

AMA-MSS National Service Project in Chicago: Medication Take Back Day

AMA-MSS Committee on Community Service

9:00am–12:00pm | Metropolitan Water Reclamation District of Greater Chicago Headquarter Building
100 E Erie St, Chicago, Illinois

It is common to have expired or unneeded medications in your home. These pose a safety risk, as they can easily fall into the wrong hands. However, simply throwing medications in the trash can threaten the environment. Together, the American Medical Association and the Metropolitan Water Reclamation District are hosting a medication take back event on Saturday, June 10 in Chicago. You can quickly drop off any unwanted medications, and they will be safely disposed of. See the [Facebook page](#) for more information.

How to Impress on Wards

Sponsored by Kaplan Medical

9:30–10:30am | Hong Kong (West Tower)

This event would focus on providing advice on what students need to do to stand out on wards from the perspective of a physician who works with med students on rotations. The hope is to share best practices/advice and ensure a smooth transition for students from the med school classroom to a clinical environment.

Guest speaker: Mark Hill, MD, FACS, Professor of Surgery, The Chicago Medical School

Forum on the Intersectionality of Minority and LGBTQ Health

AMA Minority Affairs Section (AMA-MAS) and the Advisory Committee on LGBTQ Issues

10:00am–12:00pm | Randolph 3

See AMA LGBTQ flyer for full details.

How to Read an Insurance Card

AMA-MSS Committee on Economics and Quality in Medicine

10:30–11:30am | Hong Kong (West Tower)

Premium, deductible, co-payment, coinsurance, exclusions, coverage limits, what do all of these terms mean when it comes to healthcare coverage for our patients? As providers, it is important to understand the differences in insurance plans to optimize the immediate and long-term health of those in our care. This session will begin with a presentation on insurance plan design and terminology. Following the presentation, attendees will break into teams to analyze a clinical vignette and understand how the treatment plan evolves with different insurance plans. By the end of the session, students will understand that their approach to treating patients will involve not just integrating clinical knowledge but a patient's insurance situation.

AMA Medical Specialty Showcase & Clinical Skills Workshop

11:30am–1:30pm | Riverside Exhibit Hall (East Tower)

Discover more than 40 specialty societies and professional interest medical associations and receive career advice from physicians and residents at these organizations. Also, take the opportunity to gain hands-on instruction on essential medical skills such as airway management, ultrasound, splinting, suturing, proper blood pressure techniques and more from the AMA Clinical Skills Workshop.

Enter the Sweepstakes by submitting an entry form at any of the exhibitor booths. Prizes include \$100 Hertz certificates, \$100 Amazon gift card, Health Systems Science textbook, gift sets from the AMA and JAMA, and **one free registration for the 2018 AMA Medical Student Advocacy and Region Conference.**



Specialty Showcase Exhibitors: Specialty Societies and Professional Interest Medical Associations

Aerospace Medical Association	American Congress of Obstetricians and Gynecologists (ACOG)
AMDA-The Society for Post-Acute & Long-Term Care Medicine	American Psychiatric Association
American Academy of Family Physicians (AAFP)	American Society of Anesthesiologists
American Academy of Hospice and Palliative Medicine	American Society of Clinical Oncology
American Academy of Neurology	American Society of Echocardiography
American Academy of Orthopaedic Surgeons	American Society of Hematology
American Academy of Otolaryngology-Head and Neck Surgery	American Society of Plastic Surgeons (ASPS)
American Academy of Pain Medicine	American Society of Transplant Surgeons (ASTS)
American Academy of Pediatrics	American Thoracic Society
American Academy of Physical Medicine and Rehabilitation	American Urological Association
American Association for Geriatric Psychiatry	American Society for Clinical Pathology (ASCP)
American Association of Clinical Endocrinologists and Endocrine Society	College of American Pathologists
American Association of Hip and Knee Surgeons	Dermatology Section Council
American College of Cardiology	American College of Physicians
American College of Chest Physicians (CHEST)	Obesity Medicine Association
American College of Correctional Physicians	American College of Preventive Medicine
American College of Emergency Physicians	Radiological Society of North America
American College of Occupational and Environmental Medicine	Society of Interventional Radiology (SIR)
American College of Phlebology	Society of Nuclear Medicine and Molecular Imaging and American College of Nuclear Medicine
American College of Radiology	The Society of Thoracic Surgeons
American College of Surgeons	



AMA House of Delegates
2017 Annual Meeting
Hyatt Regency Chicago, Illinois
June 10-14

Saturday, June 10		
	AMA House of Delegates	AMA-MSS Caucus Meetings
2:00pm	AMA House of Delegates Opening Session (2-6pm Grand Ballroom) Rules of order, speeches, nominations, other presentations	
6:00pm		AMA-MSS Caucus (6-8pm Columbus K/L)
Sunday, June 11		
8:00am	AMA House of Delegates Second Opening Session (8-8:30am Grand Ballroom) Business - Introduction of Reports and Resolutions, Extraction of Information Reports, Supplementary Report of the Committee on Rules & Credentials	
8:30am	AMA Reference Committee Hearings (8:30am-12pm) Reference Committee A Regency A Reference Committee C Regency C Reference Committee E Regency D Reference Committee F Grand Ballroom (1:30-5pm) Reference Committee on Amendments to Constitution & Bylaws Regency C Reference Committee B Regency B Reference Committee D Regency D Reference Committee G Regency A	
12:00pm		
5:00pm		AMA-MSS Caucus (5-7pm Columbus I/J)

Monday, June 12		
	AMA House of Delegates	AMA-MSS Caucus Meetings
9:30am		Joint AMA-MSS / RFS / YPS Caucus (9:30-11am Crystal B)
2:00pm	AMA House of Delegates Business Section (2-6pm Grand Ballroom)	
6:00pm		AMA-MSS Caucus (6-7:30pm Columbus E/F)
Tuesday, June 13		
7:30am	Elections (7:30-8:45am)	
9:00am	AMA House of Delegates Business Section (9am-3pm Grand Ballroom)	
3:00pm		AMA-MSS Caucus (3-4:30pm Columbus I/J)
5:00pm	Inauguration Ceremony of David O. Barbe, MD (5pm Crystal Ballroom)	
6:30pm	Inaugural Reception and Dinner Dance (6:30pm Grand Ballroom)	
Wednesday, June 14		
8:00am	AMA House of Delegates Business Section (8am-12pm Grand Ballroom)	



2017 AMA Medical Student Section Annual Meeting

Hyatt Regency Chicago, Illinois

June 8-10

Convention Committees

Community Service Committee

GC Liaison: Jayme Looper, At-Large Officer

Ghamar Bitar, Co-Chair
Laura Rasmussen, Co-Chair
Saharsh Mehta
Elaina Molter
Mounica Paturu
Shejuti Paul
Amandeep Saini
Alexandra Simpson
Jessica Sundleaf
Kimberly Vu

Geisinger Commonwealth SOM
Sanford SOM University of South Dakota
University of Massachusetts Med School
Central Michigan COM
Washington University SOM
University of Alabama SOM Birmingham
NYIT College of Osteopathic Medicine
University of Alabama SOM Birmingham
Sanford SOM University of South Dakota
University of California, Irvine SOM

Credentials Committee

GC Liaisons: Lee Ouyang, Vice Chair

Ludwig Koeneke-Hernandez, Chair
Kiara Blough
Mashfee Khan
Emal Lesha
Hannah Martin
Manna Varghese
Alexandra Schwann
Christopher Vo

Thomas Jefferson University SKMC
Rocky Vista University College of Osteopathic Medicine
University of Texas Medical Branch at Galveston
Tufts University School of Medicine Boston
Tufts University School of Medicine Boston
University of Missouri Kansas City SOM
University of Toledo College of Medicine
University of California, Irvine SOM

House Coordination Committee

GC Liaisons: Sarah Mae Smith, Delegate | William Estes, Alternate Delegate

Michelle Knopp, Chair
Brandon Tabman, Chair
Brian Chernak, Vice Chair
Anna Beth West, Vice Chair
Brian Chernak
Samantha King
Lauren Engel
Eric Balaban

Ohio St University College of Medicine
Ohio St University College of Medicine
SUNY Downstate College of Medicine
University of Florida College of Medicine
SUNY Downstate Med Center COM
Ohio St University COM
Medical College of Wisconsin
Pennsylvania St University COM

House Coordination Committee (continued)

Nathan Carpenter	Medical College of Wisconsin
Daniel Ramon	University of South Florida COM
Lauren Fuller	Baylor COM
Faith Mason	UTMB - Galveston
Varun Menon	Vanderbilt University SOM
Christine Ward	East Carolina University Brody SOM
Will Lightfoot	University of South Alabama College of Medicine
Ali Bokhari	New York College of Osteopathic Med
Lawrence Lucas	University of South Carolina SOM, Greenville
Hari Iyer	Northeast Ohio Medical University
Palavi Vaidya	University of Toledo COM
Caitlin Curcuro	University of Missouri SOM Kansas City

Hospitality Committee

GC Liaison: Hunter Pattison, Speaker | Theresa Phan, Vice Speaker

Fatima Mirza, Chair	Yale University SOM
Heather Minton	University of Alabama SOM Birmingham
Vipawee Chat	Medical College of Georgia SOM
Mohammed Miniato	University of Toledo COM
Celeste Peay	Boston University SOM
Ashley Tarchione	University of Nevada SOM Reno
Yannan Wang	Medical College of Georgia SOM

Logistics Committee

GC Liaisons: Hunter Pattison, Speaker | Theresa Phan, Vice Speaker

Nazish Malik, Chair	Texas A & M University COM College Station
Connor Mcnamee	University of Toledo COM
Vartan Pahalyants	Harvard Med School
Sze Tan	University of Miami Miller SOM
Junaid Yasin	University of Missouri SOM Columbia
Gabrielle Cahill	University of California, San Diego SOM
Katherine Chen	University of Toledo COM
Ted Cho	Georgetown University SOM
Maren Loe	Washington University SOM
Najah Khan	Texas A & M University COM College Station

Parliamentary Procedure Committee

GC Liaison: Christopher Libby, Chair

Enio Perez, Chair	Medical College of Wisconsin
Roxanne Lockhart	University of Alabama SOM Birmingham
Gabriel Pham	University of Cincinnati COM
Kevin Stephenoff	University of Toledo COM
Benjamin Echols	University of Alabama SOM Birmingham
Jared Roberts	University of Utah SOM
Sierra Tackett	Medical College of Wisconsin

Reference Committee

GC Liaisons: Hunter Pattison, Speaker | Theresa Phan, Vice Speaker

Karen Dionesotes, Chair
Celsa Tonelli, Vice Chair
Kevin Qin, Vice Chair
Alexandra Rojek
Maximilian Pany
Matthew Phillips
Eric Lakey
Danny Vazquez
J. Steven Ekman

Creighton University SOM
Touro College of Osteopathic Med New York
University of Toledo COM
University of California, San Francisco SOM
Harvard Medical School
Ohio St University COM
University of Colorado SOM
Harvard Medical School
Washington University SOM

Rules Committee

GC Liaisons: Hunter Pattison, Speaker | Theresa Phan, Vice Speaker

Brianna Whithorn, Chair
Hayden Pacl
Jared Friedman
Hallie Hahn
Emily Mannix
Kyle Keller

Campbell University School of Osteopathic Medicine
University of Alabama SOM Birmingham
University of Toledo COM
Med University of South Carolina COM
University of California, San Diego SOM
University of Toledo COM

A-17 SEATING CHART

PLATFORM

DC 4		VA 8	
NJ 8		VA 4	
NJ 2	MD 6	PA 4	
PA 12			
PA 8		AL 4	
TN 10			AL 2
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GA 2	FL 10		
FL 12			
FL 8		PR 2	NC 2

SC 8		NC 4	
WI 6		IA 4	NC 2
IL 12			
IL 12			
MO 12			
MO 2	NE 10		
NE 2	MN 6	MI 4	
MI 12			
MI 12			
EXTRA 2	KY 6	MI 4	
PIMA	NMSS	NMSO	

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NY 12			
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MA 12			
CT 6		VT 2	NH 2
RI 2			
CO 4	NM 2	NV 2	OR 4
WWAMI 4	WA 4		CA 4
AZ 8			CA 4
CA 12			
CA 8		EXTRA 4	

SD 8		MT 2	HI 2
ND 2	LA 6		MS 4
KS 4	AR 2	TX 4	
OK 6		TX 4	
WV 2	TX 10		
WV 2	TX 10		
WV 6		OH 6	
OH 10			EXTRA 2
IN 10			EXTRA 2
IN 10			EXTRA 2
PIMA	NMSS	NMSO	

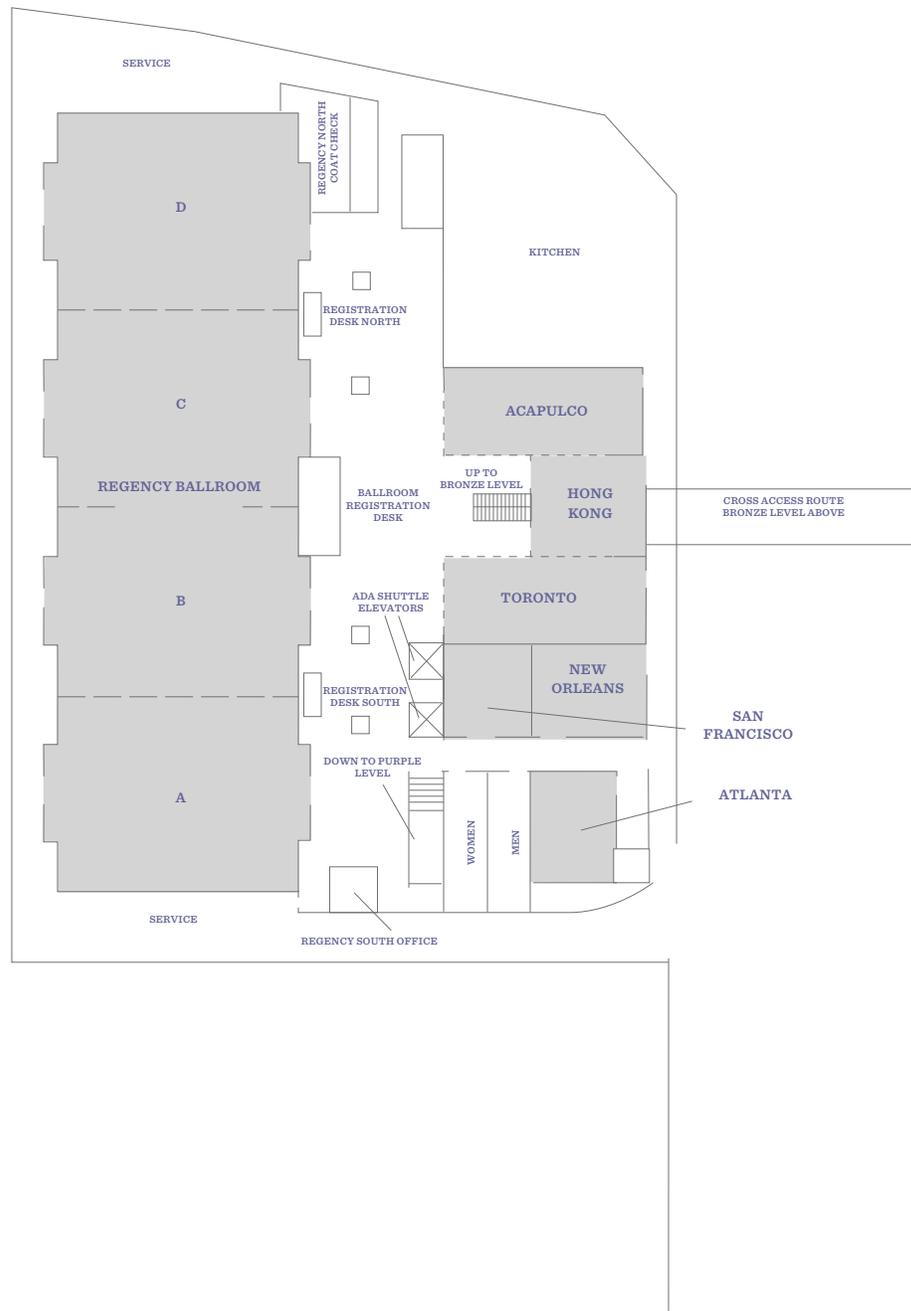
HYATT REGENCY CHICAGO

151 East Wacker Drive
Chicago, IL 60601
USA

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F +1 312 239 4541
chicagoregency.hyatt.com



FLOOR PLAN
Gold Level (West Tower)



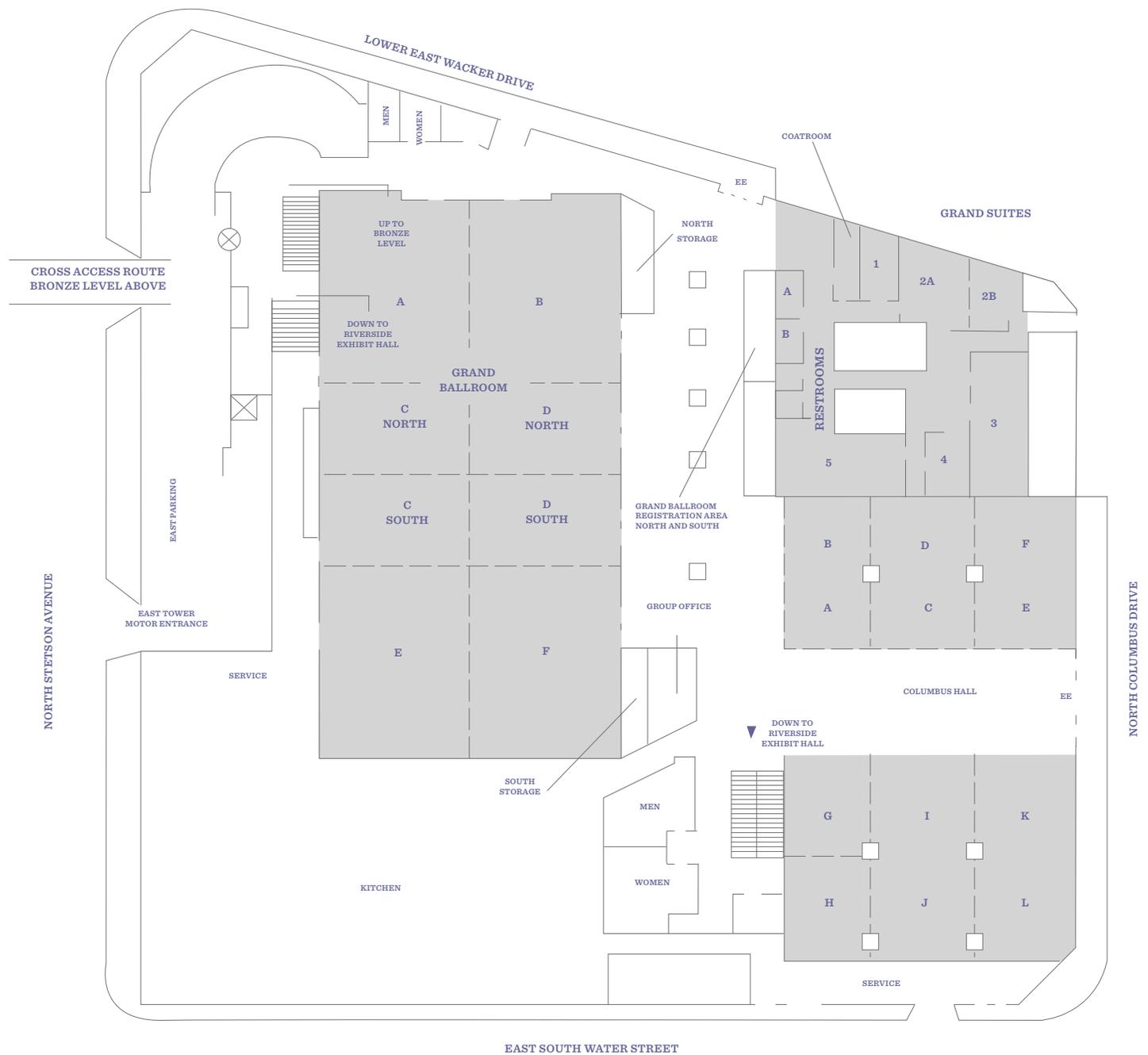
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FLOOR PLAN Gold Level (East Tower)



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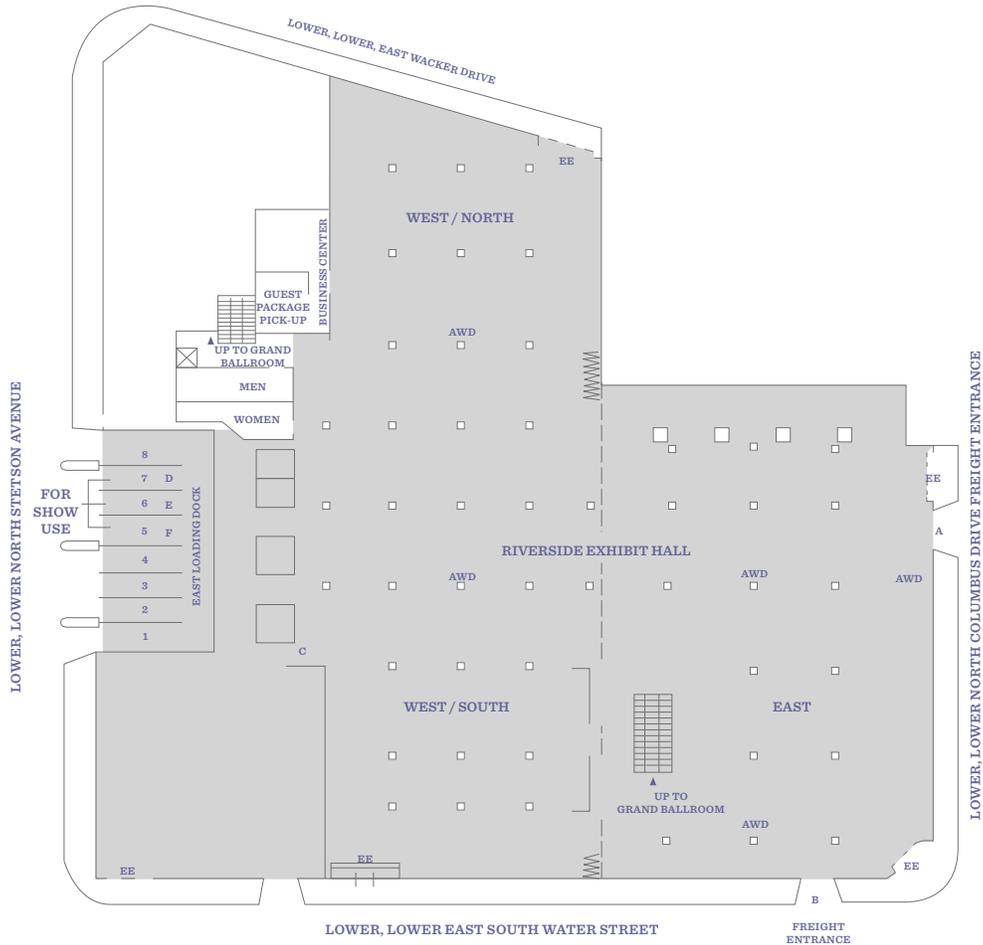
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CAPACITY CHART



Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet	Reception	Theater	Classroom	Boardroom	U-Shape	Hollow Square	Exhibit
Purple Level (East Tower)										
RIVERSIDE EXHIBIT HALL										
HALL	CEILING HEIGHT 12'	70,000	2,676	7,000	—	—	—	—	—	355
EAST	—	30,000	1,044	2,500	—	—	—	—	—	151
WEST	—	40,000	1,596	4,500	3,315	—	—	—	—	204
EAST DOCK (D, E, F)	—	3 Bays	—	—	—	—	—	—	—	—



Note: Above setups are tables and chairs ONLY without space left for other equipment such as staging, AV, display tables, registration tables or coffee breaks.

SOURCE – American Institute of Parliamentarians Standard Code of Parliamentary Procedure (Current Edition)

BASIC RULES GOVERNING MOTIONS

<i>Order of precedence</i> ¹	<i>Can interrupt?</i>	<i>Requires a second?</i>	<i>Debatable?</i>	<i>Amendable?</i>	<i>Vote required?</i>	<i>Applies to what other motions?</i>	<i>Can have what other motions applied to it?</i> ⁵	<i>Renewable?</i>
PRIVILEGED MOTIONS								
1. Adjourn	No	Yes	Yes ²	Yes ²	Majority	None	Amend, close debate, limit debate	Yes
2. Recess	No	Yes	Yes ²	Yes ²	Majority	None	Amend, close debate, limit debate	Yes ⁶
3. Question of privilege	Yes	No	No	No	None	None	None	Yes
SUBSIDIARY MOTIONS								
4. Table	No	Yes	No	No	2/3	Main motion	None	No
5. Close debate	No	Yes	No	No	2/3	Debatable motions	None	Yes
6. Limit or extend debate	No	Yes	Yes ²	Yes ²	2/3	Debatable motions	Amend, close debate	Yes ⁶
7. Postpone to a certain time	No	Yes	Yes ²	Yes ²	Majority	Main motion	Amend, close debate, limit debate	Yes ⁶
8. Refer to committee	No	Yes	Yes ²	Yes ²	Majority	Main motion	Amend, close debate, limit debate	Yes ⁶
9. Amend	No	Yes	Yes ³	Yes	Majority	Rewordable motions	Amend, close debate, limit debate	No ⁶
MAIN MOTIONS								
10. (a) The main motion	No	Yes	Yes	Yes	Majority	None	Subsidiary	No
(b) Specific main motions								
Adopt in-lieu-of	No	Yes	Yes	Yes	Majority	None	Subsidiary	No
Amend a previous action	No	Yes	Yes	Yes	Same Vote	Adopted main motion	Subsidiary	No
Ratify	No	Yes	Yes	Yes	Same Vote	Adopted main motion	Subsidiary	No
Recall from committee	No	Yes	Yes ²	No	Majority	Referred main motion	Close debate, limit debate	No
Reconsider	Yes ⁴	Yes	Yes ²	No	Majority	Vote on main motion	Close debate, limit debate	No
Rescind	No	Yes	Yes	No	Same Vote	Adopted main motion	Subsidiary, except amend	No
INCIDENTAL MOTIONS								
<i>No order of precedence</i>	<i>Can interrupt?</i>	<i>Requires a second?</i>	<i>Debatable?</i>	<i>Amendable?</i>	<i>Vote required?</i>	<i>Applies to what other motions?</i>	<i>Can have what other motions applied to it?</i> ⁵	<i>Renewable?</i>
MOTIONS								
Appeal	Yes	Yes	Yes	No	Majority ⁷	Ruling of chair	Close debate, limit debate	No
Suspend the rules	No	Yes	No	No	2/3	Procedural rules	None	Yes
Consider informally	No	Yes	No	No	Majority	Main motion or subject	None	Yes
REQUESTS								
Point of order	Yes	No	No	No	None	Procedural error	None	No
Inquiries	Yes	No	No	No	None	All motions	None	No
Withdraw a motion	Yes	No	No	No	None ⁸	All motions	None	No
Division of question	No	No	No	No	None ⁸	Main motion	None	No
Division of assembly	Yes	No	No	No	None ⁸	Indecisive vote	None	No

¹ Motions are in order only if no motion higher on the list is pending. Thus, if a motion to close debate is pending, a motion to amend would be out of order; but a motion to recess would be in order, since it outranks the pending motion.

² Restricted.

³ Is not debatable when applied to an undebatable motion.

⁴ A member may interrupt the proceedings but not a speaker.

⁵ Withdraw may be applied to all motions.

⁶ Renewable at the discretion of the presiding officer.

⁷ A tie or majority vote sustains the ruling of the presiding officer; a majority vote in the negative reverses the ruling.

⁸ If decided by the assembly, by motion, requires a majority vote to adopt



MEMORANDUM

The Medical Student Section again utilized a completely [Virtual Reference Committee](#) (VRC) for the 2017 Annual Meeting. The VRC allows students to access, review, and provide testimony on the resolutions and reports in advance of the Interim Meeting and in lieu of the standard in-person Reference Committee Hearing.

These comments were reviewed by the Reference Committee to create the final Reference Committee Report, which will be made available on Friday, June 2, one week in advance of the MSS Assembly Meeting. The final report and its recommendations will serve as the basis for extraction, discussion, and voting at the onsite Assembly Meeting on Friday June 9 at 8:00 AM.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 01
(A-17)

Introduced by: Region 1; Region 2; Region 3; Region 4; Region 7
Subject: Protection of Transgender Individuals' Right to Use Public
Facilities in Accordance with Their Gender Identity
Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, A person's gender identity, or innate identification as a man, woman or something
2 else, may or may not correspond to their biological sex assigned at birth;¹ and
3
4 Whereas, the Diagnostic and Statistical Manual, 5th Edition defines gender dysphoria as a
5 conflict between a person's gender assigned at birth and the gender with which he/she/they
6 identify, resulting in significant distress;² and
7
8 Whereas, Social transition is a medically indicated treatment modality for a transgender
9 individual experiencing Gender Dysphoria, and using public facilities in accordance with their
10 gender identity is an essential component of the social transition;² and
11
12 Whereas, 75.1% of transgender high school students report feeling unsafe at school,
13 compared to the less than one third of their non-transgender classmates;³ and
14
15 Whereas, young people with gender dysphoria were 5.1 times more likely to talk about suicide
16 and 8.6 times more likely to inflict self-harm or attempt suicide, compared to their peers;^{4, 5} and
17
18 Whereas, Harassment in public restrooms is common for transgender and gender
19 nonconforming individuals;^{6,7} and
20
21 Whereas, Transgender individuals have reported avoiding public facilities at school or work due
22 to fear of confrontation, and some will even forgo eating or drinking to avoid using a public
23 restroom;^{3, 8} and
24
25 Whereas, Individuals with limited access to public facilities are at increased risk of urologic
26 dysfunction, including kidney stones, bladder cancer, and urinary infections;⁹ and
27
28 Whereas, thirteen states have currently pending legislation restricting bathroom use and of
29 these, ten have policy options specific to schools;¹⁰ and
30
31 Whereas, Literature has shown that public accommodations discrimination in the past 12
32 months in healthcare settings is independently associated with a 31% increased risk of adverse
33 emotional and an 81% increased risk of physical symptoms;¹¹ therefore be it

RESOLVED, That our AMA-MSS acknowledges the increased risk of psychological, emotional, physical, and medical harm to transgender individuals inherent in obligating the use of public facilities inconsistent with their gender identity; and be it further

RESOLVED, That our AMA-MSS supports transgender individuals' right to use public facilities in accordance with their gender identity.

Fiscal note: TBD

Date received: 04/20/2017

References:

1. Fenway Health. Glossary of gender and transgender terms. Boston (MA): Fenway Health; 2010.
2. Parekh R, ed. What Is Gender Dysphoria? What Is Gender Dysphoria? <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria>. Accessed April 11, 2017.
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4. Aitken, Madison, Doug P. Vanderlaan, Lori Wasserman, Sonja Stojanovski, and Kenneth J. Zucker. "Self-Harm and Suicidality in Children Referred for Gender Dysphoria." *Journal of the American Academy of Child & Adolescent Psychiatry* 55.6 (2016): 513-20. Web
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8. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Ana , M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.
9. Mass AY, Goldfarb DS, Shah O. Taxi Cab Syndrome: A Review of the Extensive Genitourinary Pathology Experienced by Taxi Cab Drivers and What We Can Do to Help. *Reviews in Urology*. 2014;16(3):99-104.
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accommodations settings: A critical public health issue for transgender and gender-nonconforming people. *Milbank Quarterly*, 93(3), 484-515.

RELEVANT AMA AND AMA-MSS POLICY:

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; and (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria.

School Violence D-515.997

Our AMA will collaborate with the US Surgeon General on the development of a comprehensive report on youth violence prevention, which should include such issues as bullying, racial prejudice, discrimination based on sexual orientation or gender identity, and similar behaviors and attitudes.

Discrimination of Women Physicians in Hospital Locker Facilities H-525.981

The AMA, in an effort to promote professional equality as guaranteed by the law, requests that appropriate organizations require: that male and female physicians have equitable locker facilities including equal equipment, similar luxuries and equal access to uniforms.

Juvenile Justice System Reform H-60.919

1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance"; policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.

6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.

7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.

8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients H-65.967

1. Our AMA supports policies that allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a physician (MD or DO) that the individual has undergone gender transition according to applicable medical standards of care.

2. Our AMA: (a) supports elimination of any requirement that individuals undergo gender affirmation surgery in order to change their sex designation on birth certificates and supports modernizing state vital statistics statutes to ensure accurate gender markers on birth certificates; and (b) supports that any change of sex designation on an individual's birth certificate not hinder access to medically appropriate preventive care.

Nondiscriminatory Policy for the Health Care Needs of LGBT Populations H-65.976

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

**Sexual Orientation and/or Gender Identity as an Exclusionary Criterion for Youth
Organization H-65.979**

Our AMA asks youth oriented organizations to reconsider exclusionary policies that are based on sexual orientation or gender identity.

**Conforming Birth Certificate Policies to Evolving Medical Standards for Transgender
Patients 65.019MSS**

AMA-MSS supports (1) policies that reduce barriers to and allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a health care provider that the individual is undergoing or has undergone gender transition according to applicable medical standards of care; and (2) that sex designation on an individual's birth certificate, or any change thereof, not hinder access to appropriate medical care. (MSS Res 12, I-13)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 02
(A-17)

Introduced by: Region 1; Ben Bush, University of South Alabama College of Medicine

Subject: Increasing the Threshold for Extraction from the Reaffirmation Calendar

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 WHEREAS, It is within the powers of an organization to supersede parliamentary
2 authority by adoption of rules or bylaws;¹ and
3

4 WHEREAS, These rules or bylaws (“procedural rules”) are adopted “to cover the
5 specific needs of the organization”;¹ and
6

7 WHEREAS, The procedural rules of the AMA and its constituent sections are contained
8 within the bylaws, Internal Operating Procedures (IOPs), or other such documents of
9 each respective constituent section;^{2,3} and
10

11 WHEREAS, The procedural rules of the AMA-MSS currently differ from the rest of the
12 AMA and its constituent sections with regards to the Reaffirmation Calendar procedures
13 in that the AMA-MSS requires “1/3 of all present delegates to vote for its extraction from
14 the Final Reference Committee report”;⁴ and
15

16 WHEREAS, The 1/3 vote of all present delegates for extraction from the Final
17 Reference Committee report (the “threshold”) was adopted by the AMA-MSS in
18 response to “the large amount of time that is spent at meetings debating resolutions that
19 are recommended for reaffirmation,” and the threshold was set as a “low bar that should
20 be met to devote valuable meeting time discussing such an issue”;⁵ and
21

22 WHEREAS, Over 9 meetings of the MSS Assembly since Annual 2012 (A-12), out of 80
23 total resolutions recommended for reaffirmation, 62 were ultimately reaffirmed;⁵⁻¹⁵ and
24

25 Whereas, Given that the recommendation for reaffirmation is sustained more than 75%
26 of the time, and that a large amount of time is still expended on such business, the
27 current threshold is not sufficient to meet its objectives; therefore be it
28

29 RESOLVED, that our AMA – MSS amend 645.031MSS by addition and deletion as
30 follows:
31

32 **645.031MSS. Policy-making Procedures**

1 (1) A minimum of 90 days before the start of a national MSS meeting, the MSS
2 Delegate and Alternate Delegate, with input from other members of the MSS
3 caucus to the AMA House of Delegates, release a list of several suggested
4 resolution topics based on perceived gaps in the MSS Digest of Actions. (2) A list
5 of all GC Action Items received during the period between MSS national
6 meetings will be included in the Meeting Handbook as official MSS Actions.
7 Additionally, the MSS should create an opportunity for the Governing Council to
8 discuss GC Action Item implementation status with interested students. (3) That
9 Reference Committees be encouraged to recommend GC Action Items in future
10 report reasoning. (4) The MSS Internal Operating Procedures will be amended in
11 order to eliminate the advocacy-only rule. (5) All authored resolutions are
12 submitted to the region of the resolution's primary author for rough draft scoring
13 using the MSS Scoring Rubric. Following the draft submission deadline, regional
14 delegates and alternate delegates will be assigned specific resolutions, for which
15 they score and subsequently contact the particular resolution's author to offer
16 feedback and suggestions prior to the MSS final resolution deadline. (6) The
17 MSS Internal Operating Procedures will be revised to require resolutions to be
18 submitted 50 days prior to the start of an Annual or Interim Meeting. (7) All
19 resolutions submitted for MSS consideration by the resolution deadline will be
20 scored blindly by the MSS House Coordinating Committee and the Regional and
21 Alternate Delegates from the 6 regions where the primary author's school is not
22 located, with each resolution's average ranking subsequently being released to
23 the author.(8) Our MSS will release detailed resolution formatting rules and an
24 easy to use template for resolution drafting, available on the MSS Resolution
25 Resources page. Resolutions not meeting the formatting guidelines will be
26 returned to the submitting author and not be accepted until properly formatted
27 within the established deadlines. (9) That the MSS Internal Operating Procedures
28 be revised to require that all resolutions recommended for reaffirmation by the
29 MSS Reference Committee will require ~~4/3~~ a simple majority of all present
30 delegates to vote for its extraction from the Final Reference Committee report.

31
32 and be it further

33
34 RESOLVED, that our AMA – MSS amend its Internal Operating Procedures by addition
35 and deletion as follows:

36
37 X.H.6. Extraction of a resolution recommended for reaffirmation by the
38 Reference Committee shall require a simple majority of delegates present
39 and voting.

Fiscal note: TBD

Date received: 04/20/2017

References:

1. Glazer et. al. *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*. New York, NY. American Institute of Parliamentarians, 2012.
2. "HOD Reference Manual." <https://www.ama-assn.org/sites/default/files/media-browser/public/hod/hod-reference-manual-2016.pdf>
3. "AMA-MSS Internal Operating Procedures." https://www.ama-assn.org/sites/default/files/media-browser/public/mss/internal_oper_proced_0.pdf
4. AMA Council on Constitution and Bylaws. "Interactive Database of Section IOPs and AMA Bylaws Relevant to the AMA Sections." <https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-constitution-and-bylaws/sections-internal-operating-procedures-september-2016.pdf>.
5. AMA-MSS Reference Committee. "A-13 Reference Committee Report."
6. "Summary of Actions: Medical Student Section Items of Business." Updated January 2017.
7. AMA-MSS Reference Committee. "A-12 Reference Committee Report."
8. AMA-MSS Reference Committee. "I-12 Reference Committee Report."
9. AMA-MSS Reference Committee. "I-13 Reference Committee Report."
10. AMA-MSS Reference Committee. "A-14 Reference Committee Report."
11. AMA-MSS Reference Committee. "I-14 Reference Committee Report."
12. AMA-MSS Reference Committee. "A-15 Reference Committee Report."
13. AMA-MSS Reference Committee. "I-15 Reference Committee Report."
14. AMA-MSS Reference Committee. "A-16 Reference Committee Report."
15. AMA-MSS Reference Committee. "I-16 Reference Committee Report."

Relevant AMA and AMA-MSS Policy:

G-600.060 Introducing Business to the AMA House

AMA policy on introducing business to our AMA House includes the following:

1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website.
2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted,

however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement.

3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.

4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution.

5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which he or she considers significant or when requested to do so by the organization, and the actions taken in response to such contacts.

6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates.

7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House.

8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy Database identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years.

9. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House.

645.031MSS Policy-making Procedures:

(1) A minimum of 90 days before the start of a national MSS meeting, the MSS Delegate and Alternate Delegate, with input from other members of the MSS caucus to the AMA House of Delegates, release a list of several suggested resolution topics based on perceived gaps in the MSS Digest of Actions. (2) A list of all GC Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions. Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students. (3) That

Reference Committees be encouraged to recommend GC Action Items in future report reasoning. (4) The MSS Internal Operating Procedures will be amended in order to eliminate the advocacy-only rule. (5) All authored resolutions are submitted to the region of the resolution's primary author for rough draft scoring using the MSS Scoring Rubric. Following the draft submission deadline, regional delegates and alternate delegates will be assigned specific resolutions, for which they score and subsequently contact the particular resolution's author to offer feedback and suggestions prior to the MSS final resolution deadline. (6) The MSS Internal Operating Procedures will be revised to require resolutions to be submitted 50 days prior to the start of an Annual or Interim Meeting. (7) All resolutions submitted for MSS consideration by the resolution deadline will be scored blindly by the MSS House Coordinating Committee and the Regional and Alternate Delegates from the 6 regions where the primary author's school is not located, with each resolution's average ranking subsequently being released to the author. (8) Our MSS will release detailed resolution formatting rules and an easy to use template for resolution drafting, available on the MSS Resolution Resources page. Resolutions not meeting the formatting guidelines will be returned to the submitting author and not be accepted until properly formatted within the established deadlines. (9) That the MSS Internal Operating Procedures be revised to require that all resolutions recommended for reaffirmation by the MSS Reference Committee will require 1/3 of all present delegates to vote for its extraction from the Final Reference Committee report.

645.023MSS Medical Student Section Policy Making Procedures:

(1) As part of its annual review of MSS policies set to sunset at each Interim meeting, the MSS Governing Council will undertake policy consolidation for at least one issue; (2) When deemed necessary by the MSS Delegate and Alternate Delegate, AMA-MSS will employ a ranking/prioritization process AMA-MSS Digest of Policy Actions/ 123 for MSS resolutions intended to be forwarded to the AMA House of Delegates; (3) The MSS Governing Council will provide the MSS with updates on actions taken on resolutions and report recommendations adopted by the MSS Assembly, similar in format to the HOD's "Implementation of Resolutions and Report Recommendations" documents, and that these updates be archived as an historical record of GC actions; (4) AMA-MSS will continue to use a Reaffirmation Consent Calendar, modeling it in the style of the House of Delegates Reaffirmation Consent Calendar; (5) The MSS Governing Council will educate the Section, specifically representatives to the MSS Assembly, on the purpose and functioning of the MSS Reaffirmation Consent Calendar; (6) AMA-MSS will continue to use and enforce the mandatory MSS Resolution Checklist; (7) When MSS policy comes up for sunset, the MSS Delegate and Alternate Delegate will, at their discretion, consider re-forwarding to the House of Delegates MSS policy that was previously forwarded but not adopted.

630.037MSS Reaffirmation Calendar:

AMA-MSS will implement and use a reaffirmation consent calendar akin to that used by the AMA-HOD and set forth in AMA Policy 545.979 and 545.974, to expedite the business of the Assembly on resolutions seeking reaffirmation of existing AMA-MSS policy. The Reaffirmation Calendar will provide "statements of support" for existing AMA policy for those resolutions deemed identical or nearly identical to existing AMA policy.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 03
(A-17)

Introduced by: Region 4; Region 6

Subject: Expanding Expedited Partner Therapy to Treat Trichomoniasis

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Trichomoniasis is the most common curable sexually transmitted infection (STI) in the
2 United States according to the Centers for Disease Control and Prevention (CDC) and the most
3 common non-viral sexually transmitted infection (STI) in the world according to the World Health
4 Organization;^{1,2} and

5
6 Whereas, Trichomoniasis is not a reportable STI³ and “and partner notification programmes are
7 not available in most clinic settings”;⁴ and

8
9 Whereas, Untreated *Trichomonas vaginalis* (TV) can increase a woman’s risk of acquiring HIV
10 and adverse pregnancy outcomes, particularly premature rupture of membranes, preterm
11 delivery, and delivery of a low birthweight infant;⁵⁻⁷ and

12
13 Whereas, The rate of reinfection among women treated for TV is very high;^{5,8} and

14
15 Whereas, The 2015 ACOG guidelines directly quote the outdated CDC 2006 EPT guidelines
16 stating that “to date, there is insufficient evidence supporting the effectiveness of expedited
17 partner therapy for the treatment of trichomoniasis or syphilis”;^{9,10} and

18
19 Whereas, According to the most recent CDC 2015 STD treatment guidelines published after the
20 2015 ACOG guidelines, “concurrent treatment of all sex partners is critical for symptomatic
21 relief, microbiologic cure, and prevention of transmission and reinfections, [...] EPT might have
22 a role in partner management for trichomoniasis and can be used in states where permissible
23 by law”;¹¹ and

24
25 Whereas, Metronidazole is an effective, curative, easy, and safe treatment for *Trichomonas*
26 *vaginalis* with recommended regimens yielding cure rates of approximately 84%–98%;^{11,12} and

27
28 Whereas, Current AMA policy already supports state legislation that permits physicians to
29 provide partner therapy for gonorrhea and/or chlamydia infections, both of which are less
30 common than Trichomoniasis (H-440.868); therefore be it

31
32 RESOLVED, That the AMA amend policy H-440.868 by addition and deletion as follows:

33
34 **H-440.868 Expedited Partner Therapy**

35 Our AMA supports state legislation that permits physicians to provide expedited partner
36 therapy to patients diagnosed with gonorrhea, ~~and/or~~ and/or chlamydia, and/or trichomoniasis
37 infection.

Fiscal note: TBD

Date received: 04/20/2017

References:

1. CDC. Trichomoniasis – CDC Fact Sheet.
2. WHO. Report on global sexually transmitted infection surveillance, 2015.
3. CDC NNDSS. 2016 Nationally Notifiable Conditions.
4. Meites, E. *et al.* Trichomoniasis: the "neglected" sexually transmitted disease. *Infect Dis Clin North Am.* 2013;27(4):755-64.
5. Alcaide, M. *et al.* The incidence of Trichomonas vaginalis infection in women attending nine sexually transmitted diseases clinics in the USA. *Sex Transm Infect.* 2016;92(1):58-62.
6. Silver, B. *et al.* Trichomonas vaginalis as a cause of perinatal morbidity: a systematic review and meta-analysis. *Sex Transm Dis.* 2014;41(6):369-76.
7. Kissinger, P. *et al.* Trichomoniasis and HIV interactions: a review. *Sex Transm Infect.* 2013;89(6):426-33.
8. Peterman, T. *et al.* High incidence of new sexually transmitted infections in the year following a sexually transmitted infection: a case for rescreening. *Ann Intern Med.* 2006;145(8):564-72.
9. American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 632, Expedited Partner Therapy in the Management of Gonorrhea and Chlamydial Infection. *Obstet Gynecol* 2015;125:1526–8.
10. CDC. Expedited partner therapy in the management of sexually transmitted diseases: review and guidance, 2006.
11. CDC. Sexually Transmitted Diseases Treatment Guidelines, 2015;64(3).
12. Uptodate. Metronidazole (systemic): Drug information. Topic 9589. Version 230.0.

RELEVANT AMA POLICY:

H-440.868 Expedited Partner Therapy

Our AMA supports state legislation that permits physicians to provide expedited partner therapy to patients diagnosed with gonorrhea and/or chlamydia infection.

H-440.979 Control of Sexually Transmitted Infections

The AMA urges increased efforts at all levels of organized medicine to bring sexually transmitted infections under control, through professional and public education, and support of the efforts of state Departments of Health, the Centers for Disease Control and Prevention, the National Institutes of Health, and other appropriate organizations.

H-440.983 Update on Sexually Transmitted Infections

The AMA (1) urges medical students, primary care residents, and physicians in all specialties to familiarize themselves with sexually transmitted infections (STI), so that they will be better able to diagnose and treat them; (2) encourages physicians to always include a sexual history as part of their routine history and physical exam; (3) encourages STI instruction, both didactic and clinical, in all medical school and primary residency programs; (4) encourages the establishment of STI fellowships by primary care specialties in order to develop a pool of clinical and research expertise in the area; (5) encourages state and local medical societies to promote STI public service TV and radio announcements in their communities; and (6) supports continued communication of updated STI information regularly through AMA publications.

H-440.996 Sexually Transmitted Disease Control

Our AMA (1) supports continued action to assert appropriate leadership in a concerted program to control sexually transmitted disease; (2) urges physicians to take all appropriate measures to reverse the rise in sexually transmitted disease and bring it under control; (3) encourages constituent and component societies to support and initiate efforts to gain public support for increased appropriations for public health departments to fund research in development of practical methods for prevention and detection of sexually transmitted disease, with particular emphasis on control of gonorrhea; and (4) in those states where state consent laws have not been modified, encourages the constituent associations to support enactment of statutes that permit physicians and their co-workers to treat and search for sexually transmitted disease in minors legally without the necessity of obtaining parental consent.

8.9 Expedited Partner Therapy

Expedited partner therapy seeks to increase the rate of treatment for partners of patients with sexually transmitted infections through patient-delivered therapy without the partner receiving a medical evaluation or professional prevention counseling.

Although expedited partner therapy has been demonstrated to be effective at reducing the burden of certain diseases, such as gonorrhea and chlamydia, it also has ethical implications. Expedited partner therapy potentially abrogates the standard informed consent process, compromises continuity of care for patients' partners, encroaches upon the privacy of patients and their partners, increases the possibility of harm by a medical or allergic reaction, leaves other diseases or complications undiagnosed, and may violate state practice laws.

Before initiating expedited partner therapy, physicians should:

- (a) Determine the legal status of expedited partner therapy in the jurisdiction in which they practice.
- (b) Seek guidance from public health officials.
- (c) Engage in open discussions with patients to ascertain partners' ability to access medical services.
- (d) Initiate expedited partner therapy only when the physician reasonably believes that a patient's partner(s) will be unwilling or unable to seek treatment within the context of a traditional patient-physician relationship.

When initiating expedited partner therapy, physicians should:

- (e) Instruct patients regarding expedited partner therapy and the medications involved.
- (f) Answer any questions the patient has.
- (g) Provide to patients educational materials to share with their partners that:
 - (i) encourage the partner to consult a physician as a preferred alternative to expedited partner therapy;
 - (ii) disclose the risk of potential adverse drug reactions;
 - (iii) disclose the possibility of dangerous interactions between the medication delivered by the patient and other medications the partner may be taking;
 - (iv) disclose that the partner may be affected by other sexually transmitted diseases that may be left untreated by the medication delivered by the patient.
- (h) Make reasonable efforts to refer the patient's partner(s) to appropriate health care professionals.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 04
(A-17)

Introduced by: Region 3; Region 4; Christine Ward, Brody School of Medicine; Trevor Cline,
UC Davis School of Medicine

Subject: Public Access To Chargemasters

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

-
- 1 Whereas, Every hospital has a Charge Description Master, or “chargemaster,” a comprehensive
2 list containing reference codes, descriptions, and list prices of all billable procedures;¹ and
3
4 Whereas, While the format and contents of the chargemaster vary between hospitals, reference
5 codes are derived from the Current Procedure Terminology (CPT) and the International
6 Classification of Diseases (ICD) coding systems and are unique to each procedure, and can
7 therefore be used to research and compare prices across different hospitals;^{1,2} and
8
9 Whereas, Self-pay or uninsured patients are often charged full chargemaster prices and gaps in
10 insurance coverage predict filing for medical bankruptcy;^{3,4} and
11
12 Whereas, Medical bills contribute to an increasing proportion of US bankruptcies; hospital bills
13 were the largest reported out-of-pocket expense for 48% of medically filed bankruptcies;⁵ and
14
15 Whereas, Since the 1980s, hospital prices have increased almost three times the rate of
16 general inflation;^{6,7} and
17
18 Whereas, Price comparison among hospitals is not possible due to incomplete or unavailable
19 chargemaster prices and difficulty in interpreting the coding language of chargemasters for
20 patients;³ and
21
22 Whereas, 56% of Americans have tried to research out-of-pocket prices for health services;
23 50% of Americans who have never checked a price are unsure how to find price information;
24 and 68% of Americans believe there is a lack of pricing information regarding the cost of
25 medical services;⁴ and
26
27 Whereas, Hospital list prices vary significantly for the same procedures, with studies indicating a
28 17-fold difference for blood tests and a 1000-fold difference in lipid panel prices within the same
29 state, creating challenges for consumers due to unpredictable pricing information;^{8,9} and
30
31 Whereas, Hospitals currently use chargemaster prices as a leverage point to increase their
32 revenue from multiple sources including Medicare, private insurers, other hospital systems, and
33 patients themselves;¹⁰ and
34
35 Whereas, The United States Government Accountability Office describes effective health
36 services price transparency as “information on specific procedures [patients] are considering”
37 with tools that “make the information [hospitals] present understandable by consumers”;¹¹ and

1 Whereas, California is the only state that requires publication of hospital chargemasters as part
2 of the Payers' Bill of Rights 2004 amendments;¹² and
3

4 Whereas, The 2016 Health Care Incentives Improvement Institute--Catalyst for Payment
5 Reform Report Card on State Price Transparency Laws gave 43 states an "F" grade, indicating
6 the widespread inadequacies in current legislative requirements regarding price transparency
7 for consumers;¹³ and
8

9 Whereas, Despite possible challenges inherent in mandated cost publication, a 2011 New
10 England Journal of Medicine article states "it is difficult to defend the obscuring of health care
11 prices";¹⁴ and
12

13 Whereas, AMA policies such as Relationship of Hospital Costs and Hospital Charges H-240.999
14 and Price Transparency D-155.987 advocate for increased healthcare price transparency; and
15

16 Whereas, A subsection of AMA policy Protecting the Patient-Physician Relationship H-165.837
17 states physicians have an obligation to advocate for financial transparency for all parties
18 involved; and
19

20 Whereas, AMA policy Patient Information and Choice H-373.998 supports requiring hospitals to
21 make "fees/prices charged for frequently provided services" available to consumers; and
22

23 Whereas, A Congressional Research Service report states that measures only requiring
24 selective reporting "provide opportunities for hospitals to game the system by lowering costs on
25 the reported procedures and raising costs on others;"¹⁵ and
26

27 Whereas, Despite a variety of methodologies being used in the "price transparency"
28 movement,¹⁶ there is no direct means for consumers to access and compare complete hospital
29 costs;
30

31 RESOLVED, That our AMA support legislation requiring health-care institutions to provide public
32 online access to their complete and current chargemaster in a searchable, consumer-friendly
33 format that includes reference codes, descriptions, and prices

Fiscal note: TBD

Date received: 04/20/2017

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2. Beck, D. *et al.* Physician Coding and Reimbursement. *Ochsner J*. 2007;7(1):8-15
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4. Schleifer, D. *et al.* How Much Will It Cost? How Americans Use Prices in Health Care. *Public Agenda Report*. March 2015.
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15. Austin, D. and Gravelle, J. Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector. CRS Report for Congress. April 2008
16. Arora, V. *et al.* The Challenge of Understanding Health Care Costs and Charges. *AMA Journal of Ethics*. 2015 Nov.;17(11):1046-1052.

RELEVANT AMA AND AMA-MSS POLICY:

Relationship of Hospital Costs and Hospital Charges H-240.999

Our AMA urges hospitals: (1) to adopt pricing policies which will more specifically relate the charge for a given item or service to the actual cost of that item or service, including an adequate profit margin;

(2) to inform the medical staff and the public of the rationale for charges which cannot be strictly related to costs;

(3) to inform medical staffs as quickly as possible of any changes in prices; and

(4) to standardize their nomenclature for services, and to group these services in the general service charge or room rate consistently from one hospital to another so as to simplify comparison.

Price Transparency D-155.987

1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.

2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.

3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.

4. Our AMA will work with states to support and strengthen the development of all-payer claims databases.

5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

Patient Information and Choice H-373.998

Our AMA supports the following principles: (1) Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system. (2) Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system. (3) In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit. (4) Federal and/or state legislation authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements, and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs. (5) Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice. (6) Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront.

BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: Sub. Res. 701, A-93; Sub. Res. 125, A-93; Reaffirmation A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: Sub. Res. 107, I-93; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; BOT Rep. 36 - I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed by Sub. Res. 107, I-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-96; Reaffirmation I-96; Reaffirmation A-97; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 9, A-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 4, A-09; Reaffirmed: CMS Rep. 3, I-09)

Protecting the Patient-Physician Relationship H-165.837

Our AMA: (1) supports protecting the patient-physician relationship by continuing to advocate for: the obligation of physicians to be patient advocates; the ability of patients and physicians to privately contract; the viability of the patient-centered medical home; the use of value-based decision-making and shared decision-making tools; the use of consumer-directed health care alternatives; the obligation of physicians to prioritize patient care above financial interests; and the importance of financial transparency for all involved parties in cost-sharing arrangements; and (2) will continue to advocate protecting the patient-physician relationship in the context of bundled payment methodologies, comparative effectiveness research and physician profiling.

Patient and Public Education about Cost of Care H-155.980

The AMA, as a part of its program to strengthen the US health care system, supports intensifying its efforts to better understand patient concerns regarding fees and other costs of health care in all settings, including the cost of medication, and supports attempts to relieve these concerns.

Value-Based Decision-Making in the Health Care System D-155.994

1. Our AMA will advocate for third-party payers and purchasers to make cost data available to physicians in a useable form at the point of service and decision-making, including the cost of each alternate intervention, and the insurance coverage and cost-sharing requirements of the respective patient.
2. Our AMA encourages efforts by the Congressional Budget Office to more comprehensively measure the long-term as well as short-term budget deficit reductions and costs associated with legislation related to the prevention of health conditions and effects as a key step in improving and promoting value-based decision-making by Congress.

Listing of Hospital Charges 155.001MSS

AMA-MSS will ask the AMA to: (1) recommend that all hospitals accredited by the Joint Commission provide their medical students, housestaff, and attending physicians with a list of commonly ordered diagnostic tests and prescribed medications with their corresponding costs to patients; and (2) recommend that such charges be included on all reporting result sheets and requisition forms. (AMA Amended Res 75, I-81, Adopted [155.990]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Amended: MSS GC Rep F, I-10)

Price Transparency in Health Care 155.003MSS

AMA-MSS supports legislation that requires insurance providers to provide an online resource for patients and physicians to calculate charges and out-of pocket expenses associated with investigations and therapies in an effort to better educate patients and physicians on health care costs, equip patients to recognize value in health care, empower patients to participate in the spending of their health care dollars, and promote one-time and long term patient savings in an effort to reduce economic strains on health care systems.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 05
(A-17)

Introduced by: Region 3; Omar Salman, Virginia Tech Carilion School of Medicine; Kara Richardson, University of Toledo College of Medicine

Subject: The Diaper Gap

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Of the 12 million American children under 3 years of age, 23% are members of
2 families earning less than 100% of the federal poverty level and an additional 23% live in
3 families earning 100% to 200% of the federal poverty level;¹⁻³ and
4

5 Whereas, Of the 43 million Americans over 65 years of age, 9.4% are living below the federal
6 poverty level;¹ and
7

8 Whereas, The national average monthly cost of diapers is \$80, amounting to annual
9 expenditures of \$936 for a family with a diaper-wearing individual, the equivalent of 14% of
10 national average annual income;^{2,4} and
11

12 Whereas, As sales of adult incontinence products and baby diapers are projected to increase
13 48% and 2.6% respectively by 2020, the economic impact of diaper purchases continues to
14 affect more individuals and families;⁵ and
15

16 Whereas, While mothers living below the poverty line are more likely to experience diaper need,
17 defined as lacking the financial means to purchase an adequate supply of diapers, diaper need
18 is a widespread issue affecting mothers of all ethnicities and economic statuses;⁶ and
19

20 Whereas, Even families with balanced budgets can fall 10-12 diapers short per week, leaving
21 families in what is often referred to as the “diaper gap.”;⁶
22

23 Whereas, Diaper need was found to occur more frequently with mothers who have mental
24 health needs, contributing to increased parenting stress and depression in addition to
25 preexisting mental health illnesses;⁴ and
26

27 Whereas, An adequate supply of diapers may reduce parental stress and depression, factors
28 that have been known to increase the risk of a child’s future behavioral, social, and emotional
29 problems;⁴ and
30

31 Whereas, Efforts by parents to ease the financial strain of diapers have resulted in attempts to
32 accelerate meeting the child’s developmental milestones, like early potty training, which are
33 inconsistent with current child development recommendations;⁷ and
34

35 Whereas, Lack of diapers or prolonged use of soiled diapers can lead to health problems,
36 including recurrent urinary tract infections, diaper dermatitis, or exacerbation of eczema, leading
37 to an increase in physician’s office and emergency room visits;^{4,7,8} and
38

1 Whereas, Cloth diapers have been shown to increase the incidence of sepsis and costs in a
2 NICU, making them a less hygienic choice of diaper and a potential strain on a family's budget
3 for laundering and additional medical care;^{7,9} and
4

5 Whereas, Child care facilities are increasingly requiring parents to provide disposable, not cloth,
6 diapers as a prerequisite for attendance;² and
7

8 Whereas, Several state legislatures including Connecticut and Illinois have proposed bills to
9 address the diaper gap;^{10,11} and
10

11 Whereas, The Hygiene Assistance for Families of Infants and Toddlers Acts of 2015 and 2016
12 were introduced in the U.S. House of Representatives and Senate, respectively, to address the
13 diaper gap by helping low-income families access and purchase diapers for their children;^{12,13}
14 therefore be it
15

16 RESOLVED, that our AMA advocate for increased access to affordable diapers through various
17 methods including the elimination of taxation.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Insurance Coverage for Complete Maternity Care H-185.997

Our AMA (1) reaffirms its policy of encouraging health insurance coverage for care of the newborn from the moment of birth;

(2) urges the health insurance industry and government to include in their plans, which provide maternity benefits, coverage for normal obstetrical care, and all obstetrical complications including necessary intrauterine evaluation and care of the unborn infant;

(3) urges the health insurance industry to offer such plans on the broadest possible basis;

(4) urges the health insurance industry to make available, on an optional basis, coverage for treatment associated with voluntary control of reproduction;

(5) will advocate for expanding coverage of maternity care to dependent women under the age of 26 on their parents' large group plans; and

(6) will advocate that individual, small and large group health plans provide 60 days of newborn coverage for all newborns born to participants in the plan.

Opposition to Proposed Budget Cuts in WIC and Head Start H-245.979

The AMA opposes reductions in funding for WIC and Head Start and other programs that significantly impact child and infant health and education.

Expanding Enrollment for the State Children's Health Insurance Program (SCHIP) H-290.971

Our AMA continues to support:

- a. health insurance coverage of all children as a strategic priority;
- b. efforts to expand coverage to uninsured children who are eligible for the State Children's Health Insurance Program (SCHIP) and Medicaid through improved and streamlined enrollment mechanisms;
- c. the reauthorization of SCHIP in 2007; and
- d. supports the use of enrollment information for participation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and/or the federal school lunch assistance program as documentation for SCHIP eligibility in order to allow families to avoid duplication and the cumbersome process of re-documenting income for child health coverage.

Adequate Funding of the WIC Program H-245.989

Our AMA urges the U.S. Congress to investigate recent increases in the cost of infant formula, as well as insure that WIC programs receive adequate funds to provide infant formula and foods for eligible children.

Tax Exemptions for Feminine Hygiene Products H-270.953

Our AMA supports legislation to remove all sales tax on feminine hygiene products.

Dignity and Self Respect H-25.997

The AMA believes that medical care should be available to all our citizens, regardless of age or ability to pay, and believes ardently in helping those who need help to finance their medical care costs. But the AMA does not believe that tax dollars of the working people of America should be used to finance medical care for any person who is financially able to pay for it. Furthermore, the AMA believes in preserving dignity and self-respect of all individuals at all ages and believes that people should not be set apart or isolated on the basis of age. The AMA believes that the experience, perspective, wisdom and skill of individuals of all ages should be utilized to the fullest.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 06
(A-17)

Introduced by: Region 5; Oscar Reyes Gaido, Johns Hopkins University School of
Medicine

Subject: Improving Appropriate Language Access and Use of Interpreters in
Healthcare Settings

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, There are 64.7 million people in the United States who speak a language other than
2 English at home, 25.9 million of whom have limited English proficiency (LEP);¹ and
3
4 Whereas, Individuals with LEP experience significant health disparities, many of which are
5 related to language access limitations serving as barriers;²⁻⁶ and
6
7 Whereas, Empirical, peer-reviewed studies have established the markedly positive impact of
8 providing *trained professional interpreters and fully bilingual health care providers* in terms of
9 patient satisfaction, patient safety, quality of care, and health outcomes;^{2,7-10} and
10
11 Whereas, Certified medical interpreters are trained and certified in medical terminology in both
12 working languages, while bilingual healthcare providers in the United States are not typically
13 trained in medical terminology of the non-English languages;¹¹⁻¹³ and
14
15 Whereas, Despite significant effort on behalf of the AMA, many healthcare providers are not
16 equipped with sufficient information regarding their legal obligations for providing language
17 services;^{11,14-16} and
18
19 Whereas, Despite the AMA's opposition to the undue financial burden placed on physicians,
20 who have no recourse for reimbursement (D-160.992), the AMA does recognize the need for
21 equal language access services (D-385.978); and
22
23 Whereas, The obligation for medical providers [and all recipients of federal funding] to provide
24 language access services in the form of interpreting and translation such that LEP patients
25 receive an equal level of access to that of native English speakers was established by Title VI of
26 the Civil Rights Act (1964) and made explicit in the 2000 affirmation by US Health and Human
27 Services Executive Order 13166;¹⁷ and
28
29 Whereas, Successful healthcare interpreting requires extensive training, and self-identification

1 as bilingual does not suffice to qualify an individual as an interpreter;¹⁸ and

2

3 Whereas, Despite existing regulations, many healthcare providers do not have proper education
4 on providing adequate language access to their patients and may therefore be unknowingly not
5 following federal and state laws;^{11,14,18-19} and

6

7 Whereas, Multiple studies have established that medical students, residents, and other
8 physicians frequently have used inadequate Spanish language skills to provide medical services
9 despite availability of professional interpretation services;^{15-16,19,20-22} and

10

11 Whereas, The Agency for Healthcare Research and Quality posted a study that stated that
12 although the provision of equal access language services is mandated, professional interpreters
13 are frequently underutilized even when available;²³ and

14

15 Whereas, The Culturally and Linguistically Appropriate Services (CLAS) standards state that
16 individuals providing language services should be competent, and the use of untrained
17 individuals or minors should be avoided;²⁴ and

18

19 Whereas, Notice of the availability of free interpreting services must be provided per the Office
20 of Civil Rights (OCR) guidelines, and the American Association of Medical Colleges (AAMC)
21 states that friends and family of the patient should only be used in the event that a trained
22 medical interpreter is not available;²⁵⁻²⁶ and

23

24 Whereas, Current AMA Policy (H-295-897) recommends enhancing the cultural competency
25 training of physicians, but do not specify training on language access and the use of
26 interpreters; and

27

28 Whereas, Current Liaison Committee on Medical Education (LCME) guidelines require cultural
29 competency training, but do not specify the need for education on how and when to use
30 interpreter services;²⁷ and

31

32 Whereas, Evidence suggests that specific medical school programs targeted toward appropriate
33 interpreter use increased the students' perceived efficacy in communicating with a patient with
34 LEP, and improved the use of the hospital language line;^{15,28} and

35

36 Whereas, Training and/or continuing education regarding language access and/or cultural
37 competency has been mandated for physicians and other health professionals in three states
38 (California, New Jersey, and Washington);²⁹ therefore be it

39

40 RESOLVED, That our AMA encourage the use of trained interpreters as a primary resource for
41 patients with limited English proficiency (LEP), when available, in the stead of patient family
42 members and friends; and be it further

43

1 RESOLVED, That our AMA encourage specific training for medical students on the appropriate
2 manner of working with interpreters; and be it further

3

4 RESOLVED, That our AMA encourage the inclusion of appropriate language access and use of
5 interpreters to existing physician training and continuing education on cultural competency; and
6 be it further

7

8 RESOLVED, That our AMA-MSS will ask the AMA to amend policy H-295.897 by insertion as
9 follows:

10 **Enhancing the Cultural Competence of Physicians H-295.897**

11 1. Our AMA continues to inform medical schools and residency program directors about
12 activities and resources related to assisting physicians in providing culturally competent
13 care, including appropriate language access to patients throughout their life span and
14 encourage them to include the topic of culturally effective health care in their curricula.

15 2. Our AMA continues research into the need for and effectiveness of training in cultural
16 competence, using existing mechanisms such as the annual medical education surveys
17 and focus groups at regularly scheduled meetings.

18

19 3. Our AMA will form an expert national advisory panel (including representation from
20 the AMA Minority Affairs Consortium and International Medical Graduate Section) to
21 consult on all areas related to enhancing the cultural competence of physicians,
22 including developing a list of resources on cultural competencies for physicians and
23 maintaining it and related resources in an electronic database.

24 4. Our AMA will assist physicians in obtaining information about and/or training in
25 culturally effective health care through development of an annotated resource database
26 on the AMA home page, with information also available through postal distribution on
27 diskette and/or CD-ROM.

28 5. Our AMA will seek external funding to develop a five-year program for promoting
29 cultural competence in and through the education of physicians, including a critical
30 review and comprehensive plan for action, in collaboration with the AMA Consortium on
31 Minority Affairs and the medical associations that participate in the consortium (National
32 Medical Association, National Hispanic Medical Association, and Association of
33 American Indian Physicians,) the American Medical Women's Association, the American
34 Public Health Association, the American Academy of Pediatrics, and other appropriate
35 groups. The goal of the program would be to restructure the continuum of medical
36 education and staff and faculty development programs to deliberately emphasize cultural
37 competence as part of professional practice.

38 6. Our AMA encourages training opportunities for students and residents, as members of
39 the physician-led team, to learn cultural competency, including what providing equal

- 1 language access entails and the proper use of professional interpreters from community
2 health workers, when this exposure can be integrated into existing rotation and service
3 assignments.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:**Appropriate Reimbursement for Language Interpretive Services D-160.992**

1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English.

2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care. Res 209, A-03; Appended: Res 114, A-12

Patient Interpreters H-385.928

Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government. Res 219, I-01

Language Interpreters D-385.978

Our AMA will: 1) continue to work to obtain federal funding for medical interpretive services; 2) redouble its efforts to remove the financial burden of medical interpretive services from physicians; 3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; 4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and 5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense. Res 907, I-03

Interpreter Services and Payment Responsibilities H-385.917

Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services. Cms Rep 5, A-11

Interpreters For Physician Visits D-90.999

Our AMA continues to monitor enforcement of those provisions of the ADA to assure that physician offices are not subjected to undue burdens in their efforts to assure effective communication with hearing disabled patients. Bot Rep 15, I-98

Availability and Payment for Medical Interpreters Services in Medical Practices H-385.929

It is the policy of our AMA to: 1) the fullest extent appropriate, to actively oppose the inappropriate extension of the OCR LEP guidelines to physicians in private practice, and 2) continue our proactive, ongoing efforts to correct the problems imposed on physicians in private practice by the OCR language interpretation requirements. Bot Rep 25, I-01

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924

AMA policy is that: 1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care, 2) treating physicians shall

respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive, 3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid LEP patients' involvement in meaningful decisions about their care, and 4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements. Bot Rep 8, I-02

Enhancing the Cultural Competence of Physicians H-295.897

1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings.
3. Our AMA will form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database.
4. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM.
5. Our AMA will seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians,) the American Medical Women's Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice.
6. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments. CME Rep 5, A-98; Appended: Res 304, I-16

Promoting Culturally Competent Health Care H-295.905

The AMA encourages medical schools to offer electives in culturally competent health care with the goal of increasing awareness and acceptance of cultural differences between patient and provider. Res 306, A-97

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 07
(A-17)

Introduced by: Region IV

Subject: Opioid Abuse in Breastfeeding Mothers

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Neonatal Abstinence Syndrome (NAS) is defined as a group of health problems seen
2 in newborns exposed to addictive opiate drugs *in utero*, including dependency of the newborn
3 on the drug used during pregnancy associated withdrawal symptoms days after birth;¹ and
4
5 Whereas, Infants born with NAS due to maternal opioid use has increased nearly five-fold from
6 2000 to 2012;² and
7
8 Whereas, The National Institute on Drug Abuse found that the average hospital stay for an
9 infant born with NAS is 16.9 days as opposed to the 2.1 day average of non NAS infants,
10 leading to an extra \$1.5 billion in hospital expenses in the year 2012;² and
11
12 Whereas, Infants breastfed by mothers using heroin can experience tremors, restlessness,
13 vomiting, and poor feeding;³ and
14
15 Whereas, Methadone, and more recently Buprenorphine, have been found to be effective and
16 safe opioid maintenance therapies in pregnant women;⁴ and
17
18 Whereas, Methadone transmission in breast milk is only in negligible amounts;⁵ and
19
20 Whereas, The amount of Buprenorphine transmitted via breastmilk is not large enough to
21 produce acute adverse effects;⁶ and
22
23 Whereas, The benefits of breastmilk supersede the risks of infant opioid exposure;⁵ and
24
25 Whereas, Breastfeeding remains contraindicated in women with HIV, a condition associated
26 with IV drug abuse, including that of heroin;⁷ and
27
28 Whereas, Breastfeeding has been found to decrease the rate and severity of NAS in infants
29 born to mothers undergoing opioid maintenance therapy;^{5,8} and
30
31 Whereas, Seeking treatment for opioid addiction with the guidance of a physician is beneficial to
32 newborn outcomes at any point during pregnancy and is encouraged in pregnant women;⁹ and
33
34 Whereas, The American Society of Addiction Medicine advises that mothers currently receiving
35 opioid maintenance therapy should continue breastfeeding under physician supervision during
36 treatment;⁴ and
37
38 Whereas, Inadequate access to treatment for opioid addiction, limited options for medication-
assisted programs during pregnancy and breastfeeding, lack of expertise among providers

39 caring for opioid dependent pregnant and breastfeeding women and their opioid-exposed
40 neonates, and insufficient resources to care for opioid-exposed neonates in low volume
41 obstetric hospitals are challenges facing breastfeeding opioid dependent mothers, especially in
42 rural and underserved communities;¹⁰ therefore be it
43

44 RESOLVED, That our AMA will work with specialty societies such as the American Society of
45 Addiction Medicine, the American College of Obstetricians and Gynecologists, the American
46 Academy of Pediatrics, and others to create educational resources for opioid dependent
47 mothers on the benefits and risks of breastfeeding while using opioid drugs or during
48 maintenance therapy based on the most recent guidelines; and be it further
49

50 RESOLVED, That our AMA will lobby for increased access to opioid maintenance therapy for
51 breastfeeding women; and be it further
52

53 RESOLVED, That our AMA support physician training on current treatment guidelines for
54 breastfeeding mothers who are opioid dependent or currently undergoing opioid maintenance
55 therapy.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985:

1. Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice.

2. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management.

Medical Direction of Methadone Treatment H-95.977: Our AMA urges that the operation of methadone treatment programs be under the direction of physicians who are knowledgeable and competent in the treatment of addiction.

Breastfeeding H-245.997: Our AMA endorses the summary statement resulting from a study by the Committee on Nutrition of the American Academy of Pediatrics and the Nutrition Committee of the Canadian Paediatric Society, entitled, Breast-Feeding: A Commentary in Celebration of the International Year of the Child, 1979, which reads as follows: (1) Full-term newborn infants should be breast-fed, except if there are specific contraindications or when breast-feeding is unsuccessful. (2) Education about breast-feeding should be provided in schools for all children and better education about breastfeeding and infant nutrition should be provided in the curriculum of physicians and nurses. Information about breastfeeding should also be presented in public communications media. (3) Prenatal instruction should include both theoretical and practical information about breastfeeding. (4) Attitudes and practices in prenatal clinics and in maternity wards should encourage a climate which favors breastfeeding. The staff should include nurses and other personnel who are not only favorably disposed toward breastfeeding but also knowledgeable and skilled in the art. (5) Consultation between maternity services and agencies committed to breastfeeding should be strengthened. (6) Studies should be conducted on the feasibility of breastfeeding infants at day nurseries adjacent to places of work subsequent to an appropriate leave of absence following the birth of an infant.

AMA Support for Breastfeeding H-245.982: 1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places. 2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by

encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician. 3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period. 4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).

AMA Support for Breastfeeding 245.002MSS: AMA-MSS will ask the AMA to encourage perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include: (a) education of parents about the medical benefits of breastfeeding and encouragement of its practice, and (b) education of parents about formula and bottle-feeding options. (AMA Amended Res 506, A-93 Adopted [H-245.982]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Protecting a Mother's Right to Breastfeed 245.011MSS : AMA-MSS supports state legislation that clarifies and enforces a mother's right to breastfeed in a public place and will encourage all to adopt breastfeeding legislation which clarifies and protects a mother's right to breastfeed in a public place. (MSS Res 15, A-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)

Promoting Breastfeeding in Hospitals 245.013MSS: AMA-MSS will ask the AMA to: (1) strengthen the support for breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; and (2) encourage hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services. (MSS Res 27, I-03) (AMA Amended Res 412, A- 04 Adopted [D-245.997]) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (D-245.997 Rescinded: CCB/CLRPD Rep. 1, A-14)

Doctors Defending Breastfeeding 245.016MSS: AMA-MSS will ask the AMA to: (1) Discourage hospitals and health care professionals from distributing formula and bottles to women who are willing and able to breastfeed; (2) Oppose the marketing or distribution of infant formula in ways that may interfere with the protection and promotion of breastfeeding; and (3) Recognize the inherent conflict of interest present when infant formula manufacturers provide financial support for research into or professional meetings regarding infant and child feeding. (MSS Res 1, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 08
(A-17)

Introduced by: Region 1

Subject: Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

-
- 1 Whereas, The prevalence of heroin dependence increased by 90% between the period of 2002-
2 2004 and that of 2011-2013¹; and
3
4 Whereas, The number of deaths attributed to heroin injection overdoses have quadrupled
5 nationally since 2010^{2,3}; and
6
7 Whereas, Persons who inject drugs (PWID) are more likely to contract infectious diseases like
8 HIV, hepatitis C, and soft tissue infections^{4,5}; and
9
10 Whereas, Supervised injection facilities (SIFs) are sites that “allow PWID to inject self-provided
11 drugs within a supervised framework in enhanced aseptic conditions with medical monitoring
12 and no risk of police control”⁶; and
13
14 Whereas, In areas where they are established, SIFs reduce the number of overdose deaths⁷,
15 reduce transmission rates of infectious disease^{8,9}, increase the number of individuals initiating
16 substance use therapy^{10,11}, improve access to care for those that would not otherwise access
17 the health care system^{6,12,13,14}, and to date have had no documented fatalities^{11,12,17}; and
18
19 Whereas, SIFs effectively attract and provide services for PWID who are at greatest risk due to
20 homelessness, daily use, and recent nonfatal overdose^{12,17}, and it has been shown that youth in
21 high-risk categories are more likely to use SIFs^{18,19}; and
22
23 Whereas, SIFs do not increase overall illicit drug use, encourage drug use, or promote first-time
24 drug experimentation^{10,20}; and
25
26 Whereas, North America’s only currently existing SIF has created significant healthcare savings
27 due to averted infections and deaths, and cost-benefit projections for potential SIFs in other
28 North American cities have predicted similarly favorable results^{21,22,23}; and
29
30 Whereas, SIFs in other locations have demonstrated social benefits of reducing public injecting,
31 syringe litter, and local crime including vehicle break-ins and thefts^{24,25}; and
32
33 Whereas, Multiple state legislatures and localities are currently involved in efforts to create legal
34 frameworks for and facilitate the creation of SIFs or similar facilities to further combat the opioid
35 addiction crisis^{26,27,28,29}; and

1
2 Whereas, SIFs are an extension of harm reduction measures like syringe exchanges⁶, which the
3 American Medical Association presently support; and
4

5 Whereas, AMA policy is to encourage the continued study and implementation of appropriate
6 treatments and risk mitigation methods for patients at risk for opioid overdose; therefore be it
7

8 RESOLVED, That our AMA work with state and local health departments to achieve the
9 legalization and implementation of facilities that provide a supervised framework and enhanced
10 aseptic conditions for the injection of self-provided illegal substances with medical monitoring,
11 with legal and liability protections for persons working or volunteering in such facilities and
12 without risk of criminal penalties for recipients of such services.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Harm Reduction Through Addiction Treatment H-95.956

The AMA endorses the concept of prompt access to treatment for chemically dependent patients, regardless of the type of addiction, and the AMA will work toward the implementation of such an approach nationwide. The AMA affirms that addiction treatment is a demonstrably viable and efficient method of reducing the harmful personal and social consequences of the inappropriate use of alcohol and other psychoactive drugs and urges the Administration and Congress to provide significantly increased funding for treatment of alcoholism and other drug dependencies and support of basic and clinical research so that the causes, mechanisms of action and development of addiction can continue to be elucidated to enhance treatment efficacy.

The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954

Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients.

Reduction of Medical and Public Health Consequences of Drug Abuse: Update D-95.999

Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance and other opioid treatment services and programs in their states.

Syringe and Needle Exchange Programs H-95.958

Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.

Prevention of Opioid Overdose D-95.987

1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.

2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 09
(A-17)

Introduced by: Region 3; Region 5
Subject: Defending Federal Child Nutrition Programs
Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, The United States Department of Agriculture’s (USDA) child nutrition
2 programs which include resources such as the National School Lunch Program (NSLP)
3 and the School Breakfast Program (SBP) serve as vital lifelines in preserving and
4 improving the general health of children in the United States¹; and
5

6 Whereas, The cumulative cost of all USDA child nutrition programs in 2014 was 20
7 billion dollars and that figure is projected to increase to 31 billion dollars by 2025^{2,3}; and
8

9 Whereas, Of the 73.6 million school-age children in the United States, over 43 million
10 utilize NSLP and/or SBP on a given school day^{4,5}; and
11

12 Whereas, The Healthy, Hunger-Free Kids Act (HHFKA) of 2010 updated nutrition
13 standards for federal child nutrition programs and enabled the USDA to align school
14 meal program resources with its Dietary Guidelines for Americans (DGA)^{6,7}; and
15

16 Whereas, In 2012, the USDA issued updated nutritional guidelines for child nutrition
17 programs which further compelled schools to add more fruits, vegetables, and legumes
18 while reducing fat, sodium, and caloric content in provided foods⁸⁻¹⁰; and
19

20 Whereas, The USDA fiscal year 2014-2018 Strategic Plan’s Strategic Goal #4 prioritizes
21 ensuring that “all of America’s children have access to safe, nutritious, and balanced
22 meals”¹¹; and
23

24 Whereas, The USDA defines food insecurity as “a household-level economic and social
25 condition of limited or uncertain access to adequate food”¹²; and
26

1 Whereas, In 2015, more than 13.1 million children were food insecure and thereby at
2 increased risk for deficiencies in one or more nutrients, placing them at significantly
3 higher risk for illness altered cognition, and decreased mental performance¹³⁻¹⁶; and
4

5 Whereas, Early exposure to nutrition education and access to fruits and vegetables play
6 a significant role on the shaping of good longitudinal dietary habits and mitigate the risk
7 of developing early onset obesity and diseases associated with obesity such as diabetes
8 and hyperlipidemia¹⁷⁻²⁰; and
9

10 Whereas, the American Academy of Pediatrics recommends continuing “to support the
11 efforts of the USDA to improve the school nutrition environment as the best means to
12 ensure the nutritional adequacy of all school-aged children and adolescents²¹; and
13

14 Whereas, Several surveys collectively polled over 15,000 subjects with results indicating
15 that the USDA’s updated nutritional standards positively impact student fruit and
16 vegetable consumption as well as food insecurity and, in effect, its associated health and
17 nutritional complications^{17,22-25}; and
18

19 Whereas, The US Senate Committee on Agriculture, Nutrition, and Forestry successfully
20 persuaded the USDA in 2013 to grant flexibility on implementation of its 2012 school
21 meal nutritional standards and the USDA has been under continuous pressure since to
22 grant even greater or permanent flexibility in implementation of these standards²⁶⁻²⁸; and
23

24 Whereas, Several bills recently proposed in consecutive Congressional sessions have
25 demonstrated sustained interest in dissolving evidence-based nutrition standards in
26 school meal programs, increasing requirements for schools to provide meals to low-
27 income students at no charge, and reducing funding for this important federal resource
28 which, as a consequence, would exacerbate food insecurity for students from higher
29 poverty neighborhoods²⁹⁻³³; and
30

31 Whereas, The House Freedom Caucus has specifically indicated school meal nutrition
32 standards as #1 on a list of priority regulations for repeal as part of their “First 100 Days”
33 agenda³⁴; and
34

35 Whereas, Our American Medical Association (AMA) has demonstrated long-standing
36 commitment in ensuring healthy foods remain accessible to all. Yet, there currently is no
37 policy asking the AMA to make legislative efforts against efforts to reduce or eliminate
38 programs supported by its policies³⁵⁻³⁷; therefore be it
39

40 RESOLVED, That our AMA oppose legislation that reduces or eliminates funding,
41 access, or evidence-based nutritional standards for federal child nutrition programs.
42

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Quality of School Lunch Program H-150.962

The AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines.
(Reaffirmed: CSA Rep. 8, A-03) (Reaffirmed: A-07)

Support for Uniform, Evidence-Based Nutritional Rating System H-150.936

1. Our AMA supports the adoption and implementation of a uniform, nutritional food rating system in the US that meets, at a minimum, the following criteria: is evidence-based; has been developed without conflict of interest or food industry influence and with the primary goal being the advancement of public health; is capable of being comprehensive in scope, and potentially

applicable to nearly all foods; allows for relative comparisons of many different foods; demonstrates the potential to positively influence consumers' purchasing habits; provides a rating scale that is simple, highly visible, and easy-to-understand and used by consumers at point of purchase; and is adaptable to aid in overall nutritional decision making.

2. Our AMA will advocate to the federal government - including responding to the Food and Drug Administration call for comments on use of front-of-package nutrition labeling and on shelf tags in retail stores - and in other national forums for the adoption of a uniform, evidence-based nutrition rating system that meets the above-referenced criteria. (Res. 424, A-10)

Rating System for Processed Foods H-150.942

Our AMA supports the concept of a simplified, uniform nutrition rating system to be used in addition to the current food label. (Res. 408, A-08)

Excess Sodium in the Diet H-150.997

Our AMA supports continued use of its publications to inform the public of foods containing high sodium levels, and the relationship of sodium intake to the potential development and control of hypertension. (Sub. Res. 22, A-77), (Reaffirmed: CLRPD Rep. C, A-89), (Reaffirmed: Sunset Report, A-00), (Reaffirmed: Res. 408, A-01), (Reaffirmed: CSAPH Rep. 1, A-11)

Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake H-150.929

Our AMA will:

(1) Call for a step-wise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade. Food manufacturers and restaurants should review their product lines and reduce sodium levels to the greatest extent possible (without increasing levels of other unhealthy ingredients). Gradual but steady reductions over several years may be the most effective way to minimize sodium levels.

(2) To assist in achieving the Healthy People 2010 goal for sodium consumption, will work with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, and other interested partners to educate consumers about the benefits of long-term, moderate reductions in sodium intake.

(3) Recommend that the FDA consider all options to promote reductions in the sodium content of processed foods. (CSAPH Rep. 01, A-16)

American's Health H-440.859

Our AMA will: (1) make improving health through increased activity and proper diet a priority; (2) propose legislation calling on the federal government and state governments to develop new and innovative programs in partnership with the private sector that encourage personal responsibility for proper dietary habits and physical activity of individual Americans; and (3) continue to work in conjunction with the American College of Sports Medicine, American Heart Association, US Department of Health and Human Services and any other concerned organizations to provide educational materials that encourage a healthier America through increased physical activity and improved dietary habits. (Res. 201, A-09), (Reaffirmation A-12)

Addressing Obesity D-440.954

1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention. 2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions). (BOT Rep. 11, I-06), (Reaffirmation A-13), (Appended: Sub. Res. 111, A-14), (Modified: Sub. Res. 811, I-14)

Combating Obesity and Health Disparities H-150.944

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of products low in fat and cholesterol. (Res. 413, A-07), (Reaffirmation A-12), (Reaffirmation A-13)

Obesity as a Major Public Health Problem H-150.95

Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise

in the clinical management of obesity;(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity. (CSA Rep. 6, A-99), (Reaffirmation A-09), (Reaffirmed: CSAPH Rep. 1, A-09), (Reaffirmation A-10), (Reaffirmation I-10) (Reaffirmation A-12), (Reaffirmed in lieu of Res. 434, A-12), (Reaffirmation A-13), (Reaffirmed: CSAPH Rep. 3, A-13)

Prevention of Obesity Through Instruction in Public Schools H-170.961

Our AMA will urge appropriate agencies to support legislation that would require meaningful yearly instruction in nutrition, including instruction in the causes, consequences, and prevention of obesity, in grades 1 through 12 in public schools and will encourage physicians to volunteer their time to assist with such an effort. (Res. 426, A-12)

Sustainable Food D-150.978

Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation; and (3) will consider working with other health care and public health organizations to educate the healthcare community and the public about the importance of healthy and ecologically sustainable food systems. (CSAPH Rep. 8, A-09), (Reaffirmed in lieu of Res. 411, A-11), (Reaffirmation A-12), (Reaffirmed in lieu of Res. 205, A-12), (Modified: Res. 204, A-13), (Reaffirmation A-15)

Culturally Responsive Dietary and Nutritional Guidelines D-440.978

Our AMA and its Minority Affairs Section will: (1) encourage the United States Department of Agriculture (USDA) to include culturally effective guidelines that include listing an array of ethnic staples and use of multicultural symbols to depict serving size in their Dietary Guidelines for Americans and Food Guide; (2) seek ways to assist physicians with applying the USDA Dietary Guidelines for Americans and MyPlate food guide in their practices as appropriate; and (3) monitor existing research and identify opportunities where organized medicine can impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care. (BOT Rep. 6, A-04), (Modified: CSAPH Rep. 1, A-14)

Recognizing and Taking Action in Response to the Obesity Crisis D-440.980

Our AMA will: (1) collaborate with appropriate agencies and organizations to commission a multidisciplinary task force to review the public health impact of obesity and recommend measures to better recognize and treat obesity as a chronic disease; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage

through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) encourage medical schools' accrediting bodies to study and report back on the current state of obesity education in medical schools, and through this report, identify organizations that currently provide educational resources/toolkits regarding obesity education for physicians in training and, in consultation with relevant specialty organizations and stakeholders, identify gaps in obesity education in medical schools and submit recommendations for addressing those gaps. (Reaffirmed: A-04) (Reaffirmed: A-07) (Appended: A-15)

Revision of Dietary Guidelines for Americans 150.002MSS

AMA-MSS will ask the AMA to: (1) support alterations of "Dietary Guidelines for Americans" only when such alterations are based upon valid medical and scientific principles, and without regard to the economic concerns of the food industry; and (2) recommend that any panel sitting in review of "Dietary Guidelines for Americans" should appoint its membership to avoid possible conflict of interest in accordance with the Federal Advisory Committee Act (5 U.S.C App. 1, Section 5C). (AMA Res 130, A-83, Referred) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Hunger in America 150.003MSS

AMA-MSS will ask the AMA to: (1) reaffirm its opposition to any further decreases in funding levels for maternal and child health programs and (2) reaffirm its interest in continuing to support efforts to identify national food, diet, or nutrient-related public concerns. (AMA Res 132, A-86 Referred) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11)

Decreasing Incidence of Obesity and Negative Sequelae by Reducing the Cost Disparity Between Calorie-Dense, Nutrition Poor Foods and Nutrition-Dense Foods 150.020MSS

AMA-MSS will ask the AMA to (1) support efforts to decrease the price gap between calorie dense, nutrition poor (CDNP) foods and naturally nutrition dense (ND) foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrolment, of existing programs that seek to improve nutrition and reduce obesity such as the Farmer's Market Nutrition Program (FMNP) as a part of the Women, Infants, and Children (WIC) program; and (2) support the novel application of FMNP to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of ND foods in wider food distribution venues than solely farmer's markets as part of WIC. (MSS Res 23, I-09) (AMA Res 414, A-10 Adopted [H-150.937]) (Reaffirmed: MSS GC Rep A, I-14)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 10
(A-17)

Introduced by: Region IV

Subject: Improving Screening and Treatment Guidelines for Domestic Violence
against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other
Individuals

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

- 1 Whereas, Nearly 3 in 10 women and 1 in 10 men in America have experienced some form of
2 intimate partner violence, including rape, physical violence, and/or stalking;¹ and
3
4 Whereas, Victims of violence by an intimate partner report issues such as fearing injury, the
5 perpetrator limiting the victim's access to money or social support, or needing resources such
6 as medical care, legal services, housing services, victim's advocate services, and/or crisis
7 hotlines;¹ and
8
9 Whereas, In 1992 Our AMA published Diagnostic and Treatment Guidelines on Domestic
10 Violence, and at that time the authors acknowledged that the problem of violence within gay and
11 lesbian relationships was under-researched and poorly understood, and also did not
12 acknowledge violence in couples that may include a transgender or otherwise identifying
13 individual;² and
14
15 Whereas, Our AMA has not published an updated version of the Diagnostic and Treatment
16 Guidelines on Domestic Violence since 1992;² and
17
18 Whereas, The term Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Others
19 (LGBTQ+) is an umbrella term for individuals whose gender identities and sexual orientations
20 differ from those who are cisgender and heterosexual, and should be considered as an effort to
21 be more inclusive than other acronyms like LGB, LGBT, etc. which may be present in some
22 research throughout this resolution;^{3,4} and
23
24 Whereas, Violence against LGBT individuals, including domestic violence, is underreported and
25 at times falsely attributed to other kinds of violence like hate crimes;^{5,6} and
26
27 Whereas, LGBTQ+ individuals who are victims of domestic violence may have an added
28 pressure of staying in the relationship and/or seeking treatment out of fear of being outed to
29 family members, friends, or employers;^{7,8,9} and
30
31 Whereas, Some transgender individuals may be pressured to stay in an abusive relationship
32 due to their partner's threats of limiting access to sex replacement hormones or otherwise
33 exploiting their vulnerabilities with gender transitioning;^{5,10} and
34
35 Whereas, Some transgender victims of domestic violence avoid reporting their abuse or seeking
36 treatment because they do not want to add to stigma against the transgender community;¹¹ and

1
2 Whereas, Our AMA has committed to address health disparities in LGBT populations (H-
3 65.976) and has committed to address family and intimate partner violence (H-515.965);
4 therefore be it

5
6 RESOLVED, That our AMA publish an update to its 1992 Diagnostic and Treatment Guidelines
7 on Domestic Violence to reflect recent data and to address unique issues faced by the LGBTQ+
8 population; and be it further

9
10 RESOLVED, That our AMA work with appropriate stakeholders to create a comprehensive list
11 of educational resources for LGBTQ+ patients including hotlines and shelters that cater to the
12 specific needs of LGBTQ+ victims; and be it further

13
14 RESOLVED, That our AMA work with appropriate stakeholders to create resources aimed at
15 training physicians to properly identify and assess domestic violence cases in LGBTQ+ patients
16 that take into account the aforementioned risk factors and barriers; and be it further

17
18 RESOLVED, That our AMA amend H-65.976 by insertion and deletion as follows:

19
20 **Nondiscriminatory Policy for the Health Care Needs of LGBTQ+ Populations H-**
21 **65.976**

22 Our AMA encourages physician practices, medical schools, hospitals, and clinics to
23 broaden any nondiscriminatory statement made to patients, healthcare workers, or
24 employees to include "sexual orientation, sex, or gender identity" in any
25 nondiscrimination statement.

26
27 1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients'
28 sexual orientations, sexual behaviors, and gender identities enhances the ability to
29 render optimal patient care in health as well as in illness. In the case of lesbian, gay,
30 bisexual, ~~and~~ transgender, queer/questioning, and other (LGBTQ+) patients, this
31 recognition is especially important to address the specific health care needs of people
32 who are or may be LGBTQ+; (b) is committed to taking a leadership role in: (i) educating
33 physicians on the current state of research in and knowledge of LGBTQ+ Health and the
34 need to elicit relevant gender and sexuality information from our patients; these efforts
35 should start in medical school, but must also be a part of continuing medical education;
36 (ii) educating physicians to recognize the physical and psychological needs of LGBTQ+
37 patients; (iii) encouraging the development of educational programs in LGBTQ+ Health;
38 (iv) encouraging physicians to seek out local or national experts in the health care needs
39 of LGBTQ+ people so that all physicians will achieve a better understanding of the
40 medical needs of these populations; and (v) working with LGBTQ+ communities to offer
41 physicians the opportunity to better understand the medical needs of LGBTQ+ patients;
42 and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or
43 gender identity.

44 2. Our AMA will collaborate with our partner organizations to educate physicians
45 regarding: (i) the need for women who have sex with women to undergo regular cancer
46 and sexually transmitted infection screenings due to their comparable or elevated risk for
47 these conditions; and (ii) the need for comprehensive screening for sexually transmitted
48 diseases in men who have sex with men; ~~and~~ (iii) appropriate safe sex techniques to

1 avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as
2 a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning
3 individuals) experience intimate partner violence, and how sexual and gender minorities
4 present with intimate partner violence differs from their cisgender, heterosexual peers
5 and may have unique complicating factors.

6
7 3. Our AMA will continue to work alongside our partner organizations, including GLMA,
8 to increase physician competency on LGBTQ+ health issues.

9 4. Our AMA will continue to explore opportunities to collaborate with other organizations,
10 focusing on issues of mutual concern in order to provide the most comprehensive and
11 up-to-date education and information to enable the provision of high quality and
12 culturally competent care to LGBTQ+ people.

13
14 and be it further

15
16 RESOLVED, That our AMA amend policy H-515.965 by insertion and deletion as follows:

17
18 **Family and Intimate Partner Violence H-515.965**

19 (1) Our AMA believes that all forms of family and intimate partner violence are major
20 public health issues and urges the profession, both individually and collectively, to work
21 with other interested parties to prevent such violence and to address the needs of
22 victims. Physicians have a major role in lessening the prevalence, scope and severity of
23 child maltreatment, intimate partner violence, and elder abuse, all of which fall under the
24 rubric of family violence. To support physicians in practice, our AMA will continue to
25 campaign against family violence and remains open to working with all interested parties
26 to address violence in US society. Our AMA's efforts will be guided, in part, by its
27 Advisory Council on Family Violence.

28
29 (2) Our AMA believes that all physicians should be trained in issues of family and
30 intimate partner violence through undergraduate and graduate medical education as well
31 as continuing professional development. The AMA, working with state, county and
32 specialty medical societies as well as academic medical centers and other appropriate
33 groups such as the Association of American Medical Colleges, should develop and
34 disseminate model curricula on violence for incorporation into undergraduate and
35 graduate medical education, and all parties should work for the rapid distribution and
36 adoption of such curricula when developed. These curricula should include coverage of
37 the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence,
38 and elder abuse and provide training on interviewing techniques, risk assessment, safety
39 planning, and procedures for linking with resources to assist victims. Our AMA supports
40 the inclusion of questions on family violence issues on licensure and certification tests.

41
42 (3) The prevalence of family violence is sufficiently high and its ongoing character is
43 such that physicians, particularly physicians providing primary care, will encounter
44 victims on a regular basis. Persons in clinical settings are more likely to have
45 experienced intimate partner and family violence than non-clinical populations. Thus, to
46 improve clinical services as well as the public health, our AMA encourages physicians

1 to:

2 (a) Routinely inquire about the family violence histories of their patients as this
3 knowledge is essential for effective diagnosis and care;

4 (b) Upon identifying patients currently experiencing abuse or threats from intimates,
5 assess and discuss safety issues with the patient before he or she leaves the office,
6 working with the patient to develop a safety or exit plan for use in an emergency
7 situation and making appropriate referrals to address intervention and safety needs as a
8 matter of course;

9 (c) After diagnosing a violence-related problem, refer patients to appropriate medical or
10 health care professionals and/or community-based trauma-specific resources as soon as
11 possible;

12 (d) Have written lists of resources available for victims of violence, providing information
13 on such matters as emergency shelter, medical assistance, mental health services,
14 protective services and legal aid;

15 (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals
16 for these conditions upon identifying a history of family or other interpersonal violence;

17 (f) Become aware of local resources and referral sources that have expertise in dealing
18 with trauma from victimization;

19 (g) Be alert to men presenting with injuries suffered as a result of intimate violence
20 because these men may require intervention as either victims or abusers themselves;

21 (h) Recognize that individuals who identify as a sexual and/or gender minority (lesbian,
22 gay, bisexual, transgender, queer/questioning individuals) experience intimate partner
23 violence; how sexual and gender minorities present for IPV differs from their cisgender,
24 heterosexual peers and may have unique complicating factors; therefore, physicians
25 should be prepared to address intimate partner violence in these relationships.

26 (h~~i~~) Give due validation to the experience of victimization and of observed
27 symptomatology as possible sequelae;

28 (i~~j~~) Record a patient's victimization history, observed traumata potentially linked to the
29 victimization, and referrals made;

30 (j~~k~~) Become involved in appropriate local programs designed to prevent violence and its
31 effects at the community level;

32
33 (4) Within the larger community, our AMA: (a) Urges hospitals, community mental health
34 agencies, and other helping professions to develop appropriate interventions for all
35 victims of intimate violence. Such interventions might include individual and group
36 counseling efforts, support groups, and shelters.

37 (b) Believes it is critically important that programs be available for victims and
38 perpetrators of intimate violence.

39 (c) Believes that state and county medical societies should convene or join state and
40 local health departments, criminal justice and social service agencies, and local school
41 boards to collaborate in the development and support of violence control and prevention
42 activities.

43
44 (5) With respect to issues of reporting, our AMA strongly supports mandatory reporting
45 of suspected or actual child maltreatment and urges state societies to support legislation
46 mandating physician reporting of elderly abuse in states where such legislation does not

1 currently exist. At the same time, our AMA opposes the adoption of mandatory reporting
2 laws for physicians treating competent, non-elderly adult victims of intimate partner
3 violence if the required reports identify victims. Such laws violate basic tenets of medical
4 ethics. If and where mandatory reporting statutes dealing with competent adults are
5 adopted, the AMA believes the laws must incorporate provisions that: (a) do not require
6 the inclusion of victims' identities;
7 (b) allow competent adult victims to opt out of the reporting system if identifiers are
8 required;
9 (c) provide that reports be made to public health agencies for surveillance purposes
10 only;
11 (d) contain a sunset mechanism; and
12 (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all
13 mandatory reporting laws contain adequate protections for the reporting physician and to
14 educate physicians on the particulars of the laws in their states.

15
16 (6) Substance abuse and family violence are clearly connected. For this reason, our
17 AMA believes that: (a) Given the association between alcohol and family violence,
18 physicians should be alert for the presence of one behavior given a diagnosis of the
19 other. Thus, a physician with patients with alcohol problems should screen for family
20 violence, while physicians with patients presenting with problems of physical or sexual
21 abuse should screen for alcohol use.

22 (b) Physicians should avoid the assumption that if they treat the problem of alcohol or
23 substance use and abuse they also will be treating and possibly preventing family
24 violence.

25 (c) Physicians should be alert to the association, especially among female patients,
26 between current alcohol or drug problems and a history of physical, emotional, or sexual
27 abuse. The association is strong enough to warrant complete screening for past or
28 present physical, emotional, or sexual abuse among patients who present with alcohol or
29 drug problems.

30 (d) Physicians should be informed about the possible pharmacological link between
31 amphetamine use and human violent behavior. The suggestive evidence about
32 barbiturates and amphetamines and violence should be followed up with more research
33 on the possible causal connection between these drugs and violent behavior.

34 (e) The notion that alcohol and controlled drugs cause violent behavior is pervasive
35 among physicians and other health care providers. Training programs for physicians
36 should be developed that are based on empirical data and sound theoretical
37 formulations about the relationships among alcohol, drug use, and violence.

Fiscal Note: TBD

Date Received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY

Education of Medical Students and Residents about Domestic Violence Screening H-295.912

The AMA will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient.

Renewed Focus on Domestic Violence H-515.962

Our AMA will renew its commitment to combat family and intimate partner violence by including violence prevention and education as part of the ongoing strategic planning process.

Family and Intimate Partner Violence H-515.965

(1) Our AMA believes that all forms of family and intimate partner violence are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of victims. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate

partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society. Our AMA's efforts will be guided, in part, by its Advisory Council on Family Violence.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula when developed. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist victims. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter victims on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to:

- (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care;
- (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course;
- (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible;
- (d) Have written lists of resources available for victims of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid;
- (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence;
- (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from victimization;
- (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either victims or abusers themselves;
- (h) Give due validation to the experience of victimization and of observed symptomatology as possible sequelae;
- (i) Record a patient's victimization history, observed traumata potentially linked to the victimization, and referrals made;
- (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level;

(4) Within the larger community, our AMA: (a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all victims of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

(b) Believes it is critically important that programs be available for victims and perpetrators of

intimate violence.

(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA opposes the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult victims of intimate partner violence if the required reports identify victims. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of victims' identities; (b) allow competent adult victims to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that: (a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use. (b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence. (c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems. (d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior. (e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.

Resources for Victims of Domestic Abuse in the Adolescent Population D-515.998

Our AMA will develop materials on domestic violence, partner abuse, date violence, and sexual violence (including but not limited to sexual assault, sexual harassment, stalking, and cyberstalking) that are suitable for use in junior high and high schools and work with the Alliance and state medical societies in an effort to ensure the distribution and placement of these materials in junior high and high schools around the country.

Nondiscriminatory Policy for the Health Care Needs of LGBT Populations H-65.976

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian gay bisexual and transgender (LGBT) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBT; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBT Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBT patients; (iii) encouraging the development of educational programs in LGBT Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBT people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBT communities to offer physicians the opportunity to better understand the medical needs of LGBT patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBT health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBT people.

Teaching Domestic Violence Screening 295.078MSS: AMA-MSS will ask the AMA to encourage editors and publishers of medical training literature to include (1) domestic violence screening questions in recommendations and guidelines for conducting a comprehensive medical history and (2) domestic violence intervention and documentation protocols. (Reaffirmed Existing Policy in Lieu of AMA Res 402, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

Education of Medical Students About Domestic Violence Histories 295.079MSS: AMA-MSS will ask the AMA to continue its support for the education of medical students on domestic violence by advocating that medical schools and post-graduate medical programs immediately begin training students and resident physicians to sensitively inquire about family abuse with all patients regardless of chief complaint or risk. (AMA Amended Res 303, I-96 Adopted [H-295.912]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

Identifying Victims of Adult Domestic Violence 515.001MSS: AMA-MSS will ask the AMA to: (1) work with social services and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of adult domestic violence and to better serve all of the victim's needs including medical, legal and social aspects; and (2) ask the appropriate organizations to support the inclusion of curricula that address adult domestic violence (AMA Res 419, I-91 Adopted [D-515.985]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Screening Groups at High Risk for Homicide and Violent Injuries 515.003MSS: AMA-MSS will ask the AMA to support the development and issuance of educational advisories, materials, and resources for physicians to assist them in identifying, counseling, and referring individuals at high risk of homicide or violent injury. (AMA Res 403, I-94 Referred) (BOT Amended Rep 9, I-95 Adopted in Lieu of Res 403, I-94) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender Health Issues on Medical School Campuses 65.010MSS: AMA-MSS (1) supports medical student interest groups to organize AMA-MSS Digest of Policy Actions/ 12 and congregate under the auspices of furthering their medical education or enhancing patient care by improving their knowledge and understanding of various communities – without regard to their gender, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students who wish to conduct on-campus educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; (3) encourages the LCME to require all medical schools to incorporate GLBT health issues in their curricula; and (4) reaffirms its opposition to discrimination against any medical student on the basis of sexual orientation. (MSS Amended Res 28, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 11
(A-17)

Introduced by: Region 5; Periel Shapiro, and Augustus Chang, Rutgers Robert Wood Johnson Medical School; Trevor Cline, UC Davis School of Medicine

Subject: Co-location of Behavioral Health Care and Primary Care

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, The 2014 National Survey on Drug Use and Health reported that an estimated 43.6
2 million Americans over the age of 18 suffer from mental illness and 21.5 million persons aged
3 12 years or older had a substance use disorder in the past year;¹ and
4

5 Whereas, Despite the pervasiveness of mental illness in the United States, patients face
6 significant difficulties in accessing behavioral health services; geography, time, and
7 transportation are often cited as barriers to treatment access;²⁻⁶ and
8

9 Whereas, Behavioral health assessment, maintenance, and treatment are often sought in the
10 primary care setting, with 20% of all primary care visits involving a mental health component;⁷
11 and
12

13 Whereas, Collaborative care models produce better outcomes than siloed behavioral health and
14 primary care services and are cost effective in treating complex behavioral conditions;¹²⁻¹⁵ and
15

16 Whereas, Co-location of primary care and behavioral health services is an important component
17 of collaborative care as it facilitates a direct, physical integration of behavioral healthcare and
18 general medical care;^{16;23-31} and
19

20 Whereas, The American Academy of Pediatrics and American Academy of Child and
21 Adolescent Psychiatry jointly endorse co-location models wherein patients have on-site access
22 to behavioral health specialists;⁹ and
23

24 Whereas, Co-location specifically has been shown to reduce the stigma of accessing mental
25 health treatment, decrease hospital admissions and ED visit frequency, and improve both
26 physician and patient satisfaction;^{8,13-22, 29} and
27

28 Whereas, AMA policy (H-385.915) recognizes the importance of training primary care
29 physicians in the integration of physical and behavioral healthcare; and
30

31 Whereas, AMA policy (H-160.919) supports the Patient-Centered Medical Home, where “care is
32 coordinated and/or integrated across all elements of the complex health care system”; therefore
33 be it
34

35 **RESOLVED**, That our AMA-MSS supports the co-location of behavioral health services within
36 primary care clinics and other locations where primary care services are provided.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Screening and Brief Interventions for Alcohol Problems H-30.942

Our AMA in conjunction with medical schools and appropriate specialty societies advocates curricula, actions and policies that will result in the following steps to assure the health of patients who use alcohol: (a) Primary care physicians should establish routine alcohol screening

procedures (e.g., CAGE) for all patients, including children and adolescents as appropriate, and medical and surgical subspecialists should be encouraged to screen patients where undetected alcohol use could affect care. (b) Primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing. Such training should be incorporated into medical school curricula and be subject to academic evaluation. Physicians are also encouraged to receive additional education on the pharmacological treatment of alcohol use disorders and co-morbid problems such as depression, anxiety, and post-traumatic stress disorder. (c) Primary care clinics should establish close working relationships with alcohol treatment specialists, counselors, and self-help groups in their communities, and, whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine.

Providing Medical Services through School-Based Health Programs H-60.991

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

State Efforts to Expand Coverage to the Uninsured H-165.845

Our AMA supports the following principles to guide in the evaluation of state health system reform proposals:

1. Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level.
2. The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees

Health Benefits Program [FEHBP] regulations) should be used as references when considering if a given plan would provide meaningful coverage.

3. The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable.

4. The administration and governance system should be simple, transparent, accountable, and efficient and effective in order to reduce administrative costs and maximize funding for patient care.

5. Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations.

Improving Pediatric Mental Health Screening H-345.977

Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

Access to Psychiatric Beds and Impact on Emergency Medicine H-345.978

Our AMA supports efforts to facilitate access to both inpatient and outpatient psychiatric services and the continuum of care for mental illness and substance use disorders, ameliorate the psychiatric workforce shortage, and provide adequate reimbursement for the care of patients with mental illness.

Access to Mental Health Services H-345.981

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:

(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;

(2) improving public awareness of effective treatment for mental illness;

(3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;

(4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;

(5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and

(6) reducing financial barriers to treatment.

Medical, Surgical, and Psychiatric Service Integration and Reimbursement H-345.983

Our AMA advocates for: (1) health care policies that insure access to and reimbursement for integrated and concurrent medical, surgical, and psychiatric care regardless of the clinical setting; and (2) standards that encourage medically appropriate treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients.

Awareness, Diagnosis, and Treatment of Depression and Other Mental Illnesses H-345.984

1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.
2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.
3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.

Increasing Detection of Mental Illness and Encouraging Education D-345.994

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.
2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill H-345.995

Our AMA urges physicians to become more involved in pre-crisis intervention, treatment and integration of chronic mentally ill patients into the community in order to prevent unnecessary hospitalization or jail confinement.

Statement of Principles on Mental Health H-345.999

- (1) Tremendous strides have already been made in improving the care and treatment of the emotionally disturbed, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat mental illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.
- (2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has

much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.

(3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.

(4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field.

Integrating Physical and Behavioral Health Care H-385.915

Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings.

Improving Pediatric Mental Health Screening 345.003MSS

AMA-MSS will ask the AMA to (1) recognize the importance of, and support the inclusion of, mental health screening in routine pediatric physicals; and (2) work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health concerns in primary care settings. (MSS Res 29, A-10) (AMA Res 414, A-11 Adopted as Amended [H-345.977]) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep D, I-15)

Improving Mental Health Services for Pregnant and Post-Partum Mothers 420.004MSS

AMA-MSS will ask the AMA to (1) support improvements in current mental health services for women during pregnancy and postpartum; (2) support advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage from 6 weeks to 1 year postpartum; and (3) support appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum. (MSS Res 33, I-11) (AMA Res 102, A-12 Adopted as Amended [H-420.953]) (Reaffirmed: MSS GC Report A, I-16)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 12
(A-17)

Introduced by: Region 3; Region 5; Trevor Cline, UC Davis School of Medicine; Eric Xie, Johns Hopkins University School of Medicine; Adam Roussas, University of Arizona College of Medicine; Steven Young, Tufts University School of Medicine; Anna Yap, Loma Linda University School of Medicine; Dan Adam, Creighton University School of Medicine; Divya Iyer, University of Connecticut Medical Center; Rohan Rastogi, Boston University School of Medicine

Subject: National Healthcare Finance Reform: Single Payer Solution

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Despite many attempts at health system reform, the United States health care system
2 remains plagued by continued rates of uninsurance, excessive expense, unequal health
3 outcomes based on race and socioeconomic status, and is mired in inefficiency and waste;¹⁻⁴
4 and

5
6 Whereas, In 2016, there remained a substantial segment of uninsured adults ages 19-64 in the
7 United States with a large variability in uninsurance between states, with an overall estimate of
8 12% of working age adults across the US being uninsured;⁵ and

9
10 Whereas, Lack of insurance is associated with higher mortality in pediatric and adult trauma
11 patients, as well as increased rates of undiagnosed illness complicating hospital stays for adult
12 trauma patients;^{6,7} and

13
14 Whereas, Uninsurance results in approximately 30,428 “excess” deaths of working age adults
15 compared to privately-insured working age adults;⁸ and

16
17 Whereas, Uninsured Americans are more than twice as likely to be unable or delayed in getting
18 needed medical care, dental care, or prescription medicines compared to those with private
19 insurance;⁹ and

20
21 Whereas, The United States spends about 1.5-2 times as much per capita on healthcare than
22 comparable nations (as defined by UN Human Development Index) yet continues to rank poorly
23 among its peers in many markers of health outcomes including infant mortality and mortality
24 amenable to medical care;¹⁰⁻¹³ and

25
26 Whereas, Private health insurance companies operate on average with 11-12% administrative
27 overhead costs while Medicare operates with ~4.9% overhead costs;^{14,15} and

28
29 Whereas, Medicare per capita spending grew an average of 1.4% annually between 2010 and
30 2015 while private insurance per capita spending grew 3.0% annually;¹⁶ and

31

1 Whereas, Healthcare expenditures attributable to billing and insurance-related activities (\$471
2 billion) comprised 15.7% of total expenditures (\$3.0 trillion) in 2015, of which an estimated \$375
3 billion could be saved under simplified financing;¹⁶⁻¹⁸ and
4

5 Whereas, The private health insurance industry accounts for about \$200 billion annually in
6 billing and administrative costs, which would be eliminated by a single payer reform, not
7 counting the additional costs accrued by hospitals and physicians;¹⁸ and
8

9 Whereas, Private insurance companies have significantly greater variation in the amount they
10 pay to providers/facilities, resulting in considerable variation in spending and complexity in
11 health care administration compared to public insurance providers (e.g. Medicare);¹⁹ and
12

13 Whereas, US providers spend a cumulative \$144 billion annually (physician practices: \$70
14 billion, hospitals: \$74 billion) on insurance billing and documentation-related costs, while recent
15 survey data shows Canadian providers spend only 27% per capita of what US providers spend
16 for these payer-related costs;^{18,20} and
17

18 Whereas, Despite gains in individual adult coverage via Medicaid expansion, from 2001 to 2014
19 the poorest 5% of Americans had almost no gains in survival while those in middle income or
20 high income brackets have increased their life expectancy by over 2 years;³ and
21

22 Whereas, Evidence shows that Americans with complex care needs are more likely than those
23 with similar health conditions in comparable countries to defer seeking recommended care
24 partially because of the fragmented nature of our health delivery system;²¹ and
25

26 Whereas, Equal access to care has been shown to reduce racial and socioeconomic disparities,
27 for example in improved health outcomes among children of lower socioeconomic status and
28 racial minorities with perforated appendicitis;²² and
29

30 Whereas, Expanding access to care in Massachusetts through the MA health reform has not
31 affected hospital outcomes such as ICU mortality and length of stay, and expanding access in
32 the US through the ACA has not increased wait times for primary care visits;^{23,24} and
33

34 Whereas, Following the expansion of access through the implementation of the ACA, coverage
35 disparities between White, Black, and Hispanic adults declined and Black and Latino adults
36 indicated their quality of care had improved;²⁵⁻²⁷ and
37

38 Whereas, The noninterference clause preventing negotiation of drug prices by the government
39 under Medicare is specific to Part D and would not affect separate legislation;²⁸ and
40

41 Whereas, A single payer system could allow the government to effectively negotiate drug and
42 device prices for all consumers, a process currently in practice within the VA system and
43 Department of Defense, allowing them to pay roughly half as much paid by retail
44 pharmacies;^{29,30} and
45

46 Whereas, In 2016, 58% of Americans support a federally-funded healthcare program providing
47 insurance for all Americans and in 2015, a plurality of those polled supported a single payer
48 system;^{31,32} and
49

50 Whereas, While the AMA currently opposes a single payer solution because it may limit patient
51 freedom of choice (H-165.888), current private health insurance companies limit patients via
52 narrow provider networks, high deductibles, high premiums, and limited benefits;³³ and

1
2 Whereas, Previous legislative proposals indicate a national single payer system would include
3 every licensed participating provider, making the concept of provider networks obsolete,³⁴ and
4

5 Whereas, A national single payer system would protect the patient-physician relationship from
6 interference by health insurance companies, such as inconsistent access to Multiple Sclerosis
7 disease-modifying therapies or allergen immunotherapy;^{35,36} and
8

9 Whereas, The AMA-MSS currently supports a variety of solutions to expand access to care and
10 reduce costs for patients, the spirit of which would be captured in a national single payer system
11 in delivering equitable and accessible healthcare to all Americans (165.003MSS, 165.007MSS,
12 165.011MSS, 165.015MSS, 165.019MSS); and
13

14 Whereas, The AMA-MSS has existing policies on this topic that are outdated (165.007MSS(3))
15 and for which corresponding HOD policy has already been rescinded (165.005MSS); and
16

17 Whereas, The AMA-MSS supports universal healthcare, the expansion of healthcare coverage,
18 reform that achieves universal healthcare, and has asked that universal healthcare be “the
19 number one priority of the American Medical Association” (165.009MSS, 165.012MSS,
20 165.017MSS); therefore be it
21

22 RESOLVED, That our AMA-MSS support the implementation of a national single payer system;
23 and be it further
24

25 RESOLVED, That our AMA-MSS rescind policy 165.005MSS and formal support of HOD policy
26 H-165.920; and be it further
27

28 RESOLVED, That our AMA-MSS amend policy 165.007MSS by addition and deletion as
29 follows:
30

31 165.007MSS Steps in Advancing towards Affordable Universal Access to Health
32 Insurance
33

34 (1) AMA-MSS recognizes the efforts of the American Medical Association (AMA) in
35 assembling proposals for the advancement toward affordable universal access to health
36 insurance and supports *Expanding Health Insurance: The AMA Proposal for Reform*;

37 (2) AMA-MSS recognizes the efforts of the American Academy of Family Physicians
38 (AAFP) and the American College of Physicians-American Society of Internal Medicine
39 (ACP-ASIM) in assembling proposals for advancing towards affordable universal access
40 to health insurance and supports engaging in discussions with appropriate members to
41 continue to refine existing policies;_

42 ~~(3) AMA-MSS supports AMA policy D-165.974, Achieving Health Care Coverage for All:
43 That our American Medical Association join with interested medical specialty societies
44 and state medical societies to advocate for enactment of a bipartisan resolution in the
45 US Congress establishing the goal of achieving health care coverage through a
46 pluralistic system for all persons in the United States on or before January 1, 2009 that is
47 consistent with relevant AMA policy.~~

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

H-165.839 Health Insurance Exchange Authority and Operation

1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges:

A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.

B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians.

C) Physician and patient decisions should drive the treatment of individual patients.

D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.

E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.

F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.

2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges

address patient churning between health plans by developing systems that allow for real-time patient eligibility information.

H-165.856 Health Insurance Market Regulation

Our AMA supports the following principles for health insurance market regulation:

- (1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan;
- (2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection;
- (3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges;
- (4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium;
- (5) Insured individuals should be protected by guaranteed renewability;
- (6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices;
- (7) Guaranteed issue regulations should be rescinded;
- (8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.
- (9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage; and
- (10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically:
 - (a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.

H-165.838 Health System Reform Legislation

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:

- a. Health insurance coverage for all Americans

- b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
- c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
- d. Investments and incentives for quality improvement and prevention and wellness initiatives
- e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
- f. Implementation of medical liability reforms to reduce the cost of defensive medicine
- g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:

- a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
- b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
- c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
- d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
- e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another

f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

H-165.844 Educating the American People About Health System Reform

Our AMA reaffirms support of pluralism, freedom of enterprise, and strong opposition to a single payer system.

H-165.847 Comprehensive Health System Reform

1. Comprehensive health system reform, which achieves access to quality health care for all Americans while improving the physician practice environment, is of the highest priority for our AMA. 2. Our AMA recognizes that as our health care delivery system evolves, direct and meaningful physician input is essential and must be present at every level of debate.

H-165.881 Expanding Choice in the Private Sector

Our AMA will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice, and expanded individual selection and ownership of health insurance where plans are truly accountable to patients.

H-165.882 Improving Access for the Uninsured and Underinsured

Our AMA:

(1) Will assist state medical associations and local medical societies to work with states and the insurance industry to design value-based private group and individual health insurance policies. Such policies should cover with low cost-sharing those services adjudged to have the greatest health benefit, should be affordable, and should be equivalent to or an improvement over the Medicaid coverage in that state, so as to provide a continuum of gradually enhanced coverage.

(2) Supports federal legislation to encourage the formation of small employer and other voluntary choice cooperatives by exempting insurance plans offered by such cooperatives from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws, while safeguarding state and federal patient protection laws. Any support for such small

employer and voluntary purchasing cooperatives shall be strictly contingent upon safeguarding state and federal patient protections. For purposes of such legislation, small employers should be defined in terms of the number of lives insured, not the total number employed.

(3) Through appropriate channels, encourages unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches and religious groups, ethnic coalitions, and similar groups to serve as voluntary choice cooperatives for both children and the general uninsured population, with emphasis on formation of such pools by organizations which are national or regional in scope.

(4) Supports continued study of all approaches to providing health services for the uninsured and cooperation with business groups to develop approaches that are best suited to the needs of small employers.

(5) Encourages physicians, through their local county medical societies, to explore ways to work within their communities to address the expanding problem of inadequate access to care for the uninsured and underinsured and openly communicate with one another to share information about successful programs.

(6) Will offer advice or assistance to states in advocating that the Consumer Operated and Oriented Plan (COOP) advisory board and HHS ensure that new insurance issuers, including those with physician involvement, benefit from start-up loans.

(7) Will take action to restore necessary funding for new health insurance co-operatives which had applied prior to enactment of the American Tax Relief Act of 2012, which eliminated this funding, and will work with the National Alliance of State Health Co-Ops (NASHCO) and other stakeholders to request the United States Congress and the US Department of Health and Human Services to re-establish funding to support new health insurance Co-Ops, which had applied prior to the enactment of the American Tax Relief Act of 2012.

H-165.888 Evaluating Health System Reform Proposals

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.

B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.

C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.

D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures,

credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.

E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.

F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.

G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.

H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients

H-165.920 Individual Health Insurance

Our AMA:

(1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;

(2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;

(3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:

(a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;

- (b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;
 - (c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and
 - (d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;
- (4) will identify any further means through which universal coverage and access can be achieved;
- (5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;
- (6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;
- (7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;
- (8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;
- (9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;
- (10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;
- (11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;
- (12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and

state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;

(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and

(14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.

(15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution.

H-185.974 Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs

Our AMA supports parity of coverage for mental illness, alcoholism and substance use.

H-165-985 Opposition to Nationalized Health Care

Our AMA reaffirms the following statement of principles as a positive articulation of the Association's opposition to socialized or nationalized health care:

- (1) Free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations or promotion.
- (2) Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services. (Reaffirmed: BOT Rep. I-93-25; Reaffirmed: CMS Rep. I-93-5)
- (3) Full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.
- (4) Freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service.
- (5) Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, which could include patient cost sharing in an amount which does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review.
- (6) The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans.
- (7) The expansion of adequate health insurance coverage to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care, and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level.
- (8) Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving.

H-185.986 Nondiscrimination in Health Care Benefits

Our AMA reaffirms its opposition to discriminatory benefit limitations, copayments or deductibles for the treatment of psychiatric illness under existing health care plans, and opposes discrimination in any proposed plans for national health care coverage or universal access for the people who are uninsured.

D-165.936 Updated Study on Health Care Payment Models

Our AMA will research and analyze the benefits and difficulties of a variety of health care financing models, with consideration of the impact on economic and health outcomes and on health disparities and including information from domestic and international experiences.

165.003MSS Advocacy For Rapid And Timely Implementation Of The State Children's Health Insurance Program

AMA-MSS will actively promote the rapid and timely enrollment of eligible children in their State Children's Health Insurance Program through its State Medical Student Sections and chapters. (MSS Sub Res 11, I-98 Adopted) (Reaffirmed Existing Policy in Lieu of AMA Res 104, A-99) (Reaffirmed: MSS Rep E, I-03) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

165.005MSS State-Based Demonstration Projects of our AMA Plan for Reform to Expand Health Coverage

AMA-MSS will ask the AMA to: (1) work with state medical societies and other interested organizations to identify several states which would serve as appropriate and willing sites for statewide demonstration projects of our AMA plan for reform in order to expand health coverage to the uninsured and underinsured; and (2) work for passage of enabling state and federal legislation to include the refundable tax credits described in the AMA plan for reform. (MSS Res 25, A-03) (AMA Sub Res 704 Adopted [D-165.968]) (Reaffirmed: MSS Rep C, A-04) (Reaffirmed: MSS GC Report B, I-09) (D-165.968 Rescinded: CCB/CLRPD Rep. 1, A-14) (Reaffirmed: MSS GC Report A, I-16)

165.007MSS Steps in Advancing towards Affordable Universal Access to Health Insurance

(1) AMA-MSS recognizes the efforts of the American Medical Association (AMA) in assembling proposals for the advancement toward affordable universal access to health insurance and supports Expanding Health Insurance: The AMA Proposal for Reform; (2) AMA-MSS recognizes the efforts of the American Academy of Family Physicians (AAFP) and the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) in assembling proposals for advancing towards affordable universal access to health insurance and supports engaging in discussions with appropriate members to continue to refine existing policies; (3) AMA-MSS supports AMA policy D-165.974, Achieving Health Care Coverage for All: That our American Medical Association join with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States on or before January 1, 2009 that is consistent with relevant AMA policy. (MSS Rep A, A-03) (Reaffirmed: MSS Rep E, I-08) (Modified: GC Rep B, I-13)

165.009MSS Evaluation of the Principles of the Health Care Access Resolution

(1) AMA-MSS will amend the following MSS policies that pertain to universal health care access and coverage to read "affordable universal" care or coverage: MSS 165.004, MSS 165.007 and MSS 180.011; (2) AMA-MSS supports efforts to make health care more cost-effective by reducing administrative burdens, but only to such a degree that quality of care is not compromised; (3) AMA-MSS supports means of including both long-term care and prescription drug benefits into the guidelines for seeking affordable universal health care access and

coverage; (4) AMA-MSS reaffirms its support for including preventative care and early intervention services into any plan calling for affordable universal health care access and coverage by reaffirming MSS 295.022 and MSS 170.001; (5) AMA-MSS reaffirms its support for parity in mental health care coverage by reaffirming MSS policy “Disparity of Mental Health Coverage”; (6) AMA-MSS encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality of health care; and that our AMA-MSS supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; (7) AMA-MSS will adopt policy to promote outcomes research as an effective mechanism to improve the quality of medical care for all persons and urge that the results of such research be used only for educational purposes and for improving practice parameters; (8) AMA-MSS will adopt policy to address the need to increase numbers of qualified health care professionals, practitioners, and providers in underserved areas to increase timely access to quality care; (9) AMA-MSS supports the inclusion of adequate and timely payments to physicians and other providers into any plan calling for affordable universal health care access; (10) AMA-MSS reaffirms policies MSS 160.002 and MSS 160.004 that are related to the support of medical facilities for patients who are unable to afford medical care; (11) AMA-MSS reaffirms policies MSS 165.004, MSS 165.005 and MSS 165.006 and support the inclusion of the principles of continuity of health insurance coverage and continuity of medical care into any plan calling for affordable universal health care access; (12) AMA-MSS supports the inclusion of the principle of consumer choice of healthcare providers and practitioners into any plan calling for affordable universal health care access; (13) AMA-MSS supports the inclusion of reducing health care administrative cost and burden into any plan calling for affordable universal health care access. (MSS Rep C, A-04)

165.011MSS Medicaid Reform and Coverage for the Uninsured: Beyond Tax Credits

AMA-MSS will: (1) actively support the ongoing efforts of the AMA to reform Medicaid in order to increase access to health care among the uninsured and underinsured of our nation; (2) support the ongoing AMA efforts to implement graduated, refundable tax credits as a replacement for Medicaid; (3) make the active promotion and education of the AMA plan for health insurance reform a top priority; (4) work with the AMA to create and fund programming that will educate both physicians and patients about the AMA plan for insurance reform and publicize that plan to the general public; (5) ask the AMA to continue to study Health Savings Accounts in order to gain more insight into their effects on a large scale and to determine if the AMA could use them as another means of increasing health care access in our nation; and (6) ask the AMA to study other mechanisms beyond tax credits for covering America’s uninsured, including but not limited to replacing Medicaid with a publicly-controlled non-profit corporation, with report back at I-05. (MSS Rep G, A-04) (AMA Amended Res 703, I-04 [H-290.982])

165.012MSS Covering the Uninsured as AMA’s Top Priority

AMA-MSS will ask the AMA to make the number one priority of the American Medical Association comprehensive health system reform that achieves reasonable health insurance for all Americans and that emphasizes prevention, quality, and safety while addressing the broken medical liability system, flaws in Medicare and Medicaid, and improving the physician practice environment. (MSS Res 10, I-05) (AMA Amended Res 613, A-06 Adopted [H-165.847]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Report D, I-15)

165.015MSS Maintaining Insurance Coverage and Empowering State Choice

AMA-MSS (1) supports an individual mandate for health insurance coverage; and (2) supports proposals for state-choice in federal health insurance reform only if they maintain the standards of insurance quality and reach set forward under the 2010 Patients Protection and Affordable Care Act. (MSS Res 43, A-11)

165.017MSS MSS Support for State-by-State Universal Health Care

AMA-MSS supports state-level legislation to implement innovative programs to achieve universal health care, including but not limited to single-payer health insurance. (MSS Res 13, I-14)

165.019MSS Protecting Patient Access to Health Insurance and Affordable Care:

AMA-MSS will ask that our AMA advocate that any health care reform legislation considered by Congress ensures continued improvement in patient access to care and patient health insurance coverage by maintaining: (a) Guaranteed insurability, including those with pre-existing conditions, without medical underwriting, (b) Income-dependent tax credits to subsidize private health insurance for eligible patients, (c) Federal funding for the expansion of Medicaid to 138% of the federal poverty level in states willing to accept expansion, as per current AMA policy (D-290.979), (d) Maintaining dependents on family insurance plans until the age of 26, (e) Coverage for preventive health services, (f) Medical loss ratios set at no less than 85% to protect patients from excessive insurance costs; and (g) Coverage for mental health and substance use disorder services at parity with medical and surgical benefits. (MSS Late Res 01, I-16 Immediate Transmittal)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 13
(A-17)

Introduced by: Anum Naseem, Leo Hall, Lauren Newhouse, Kristy Abraham, Madeline Berschback, Samantha Arsenault, Jay Llaniguez, Wayne State University School of Medicine; Gabriel Pham, University of Cincinnati College of Medicine; Abhijit Das, Northeast Ohio Medical University

Subject: Reproductive Health Care in Religiously-Affiliated Hospitals

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Unintended pregnancies correlate with higher rates of inadequate prenatal care,
2 preterm birth, and poorer long-term physical and mental health of both child and mother and in
3 2011, 45% of pregnancies in the U.S. were unintended, a rate much higher than reported in
4 other developed nations;^{1,2,3} and
5
6 Whereas, The American College of Obstetrics and Gynecology (ACOG) currently recommends
7 the use of long-acting reversible contraception, e.g. intrauterine devices and implants, because
8 of their superior efficacy and increased access to these methods has been shown to decrease
9 unintended pregnancies, abortion, and adolescent birth rates;^{4,5,6} and
10
11 Whereas, Catholic-sponsored facilities make up 10 of the top 25 largest health systems,
12 account for 10% of all acute-care hospitals, and receive \$27 billion in Medicare and Medicaid
13 net revenue per year;⁷ and
14
15 Whereas, Thirty Catholic hospitals are federally designated as the sole community provider,
16 demonstrating the reliance many patients have on these facilities for their health needs;⁷ and
17
18 Whereas, In accordance with the “Ethical and Religious Directives for Catholic Health Care
19 Services” issued by the U.S. Conference of Catholic Bishops, Catholic health care providers are
20 prohibited from providing various reproductive health services such as contraception,
21 sterilization, certain infertility treatments and abortion even when a woman’s life or health is at
22 risk;⁸ and
23
24 Whereas, In a study contrasting women’s expectation of medical care at a religiously-affiliated
25 hospital to a secular hospital, a substantial number of women expected to receive information
26 regarding all family planning service options at Catholic hospitals, but were unaware of the
27 existing restrictions, thus impeding their ability to act as informed healthcare consumers;⁹ and
28
29 Whereas, A study at a Catholic hospital found that the institution’s limitation to access to
30 postpartum depot medroxyprogesterone acetate, a hormonal contraception injection, was

1 correlated with a significant increase in pregnancy rates within adolescent and young adults;¹⁰
2 and
3

4 Whereas, Sixty-six percent of Catholic hospitals assessed in California refused to dispense
5 emergency contraception under any circumstances, even in cases of rape, despite state
6 legislation that mandated access for sexual assault victims;¹¹ and
7

8 Whereas, The ACLU is currently suing the United States Conference of Catholic Bishops for an
9 incident at a Catholic hospital where a woman miscarrying at 18 weeks was denied emergency
10 treatment based on religious directives and was not fully informed on the severity of her
11 condition, leading to the patient's development of sepsis;¹² and
12

13 Whereas, Physicians have reported ethical conflicts with Catholic hospital policies, specifically
14 related to the restrictions on the treatment of ectopic pregnancies, tubal ligation, emergency
15 uterine evacuation during miscarriage, and lack of support arranging adequate referrals;¹³⁻¹⁶ and
16

17 Whereas, The Committee on Ethics of the ACOG has recommended that physicians who do not
18 provide reproductive health services "must provide potential patients with accurate and prior
19 notice of their personal moral commitments... [they] have the duty to refer patients in a timely
20 manner to other providers," unless it is a medical emergency in which case providers have an
21 obligation to provide care irrespective of their beliefs;¹⁷ and
22

23 Whereas, AMA's Council on Ethical and Judicial Affairs (CEJA) is currently investigating the
24 impact of religious-affiliated hospital mergers on quality and access to patient care (140.956);
25 and
26

27 Whereas, Current AMA policy protects religious-affiliated missions (H-5.995), values a
28 physician's personal beliefs, and does not require said physicians to violate personally held
29 moral principles (H-225.950), the AMA is also committed to expanding access and transparency
30 to reproductive care (D-75.997, H-5.990); therefore be it
31

32 RESOLVED, That our AMA-MSS support that physicians at religiously-affiliated hospitals notify
33 patients of their religious commitments and provide medically accurate information on the full
34 breadth of reproductive health options available for patients, including, but not limited to, all
35 forms of contraception, emergency care during miscarriages, and infertility treatments,
36 regardless of the provider's willingness to perform the aforementioned services; and be it further
37

38 RESOLVED, That our AMA-MSS endorse the timely referral of patients seeking reproductive
39 services from healthcare providers with religious commitments to accessible health care
40 systems offering the aforementioned services, all the while avoiding any undue burden to the
41 patient.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

1. Truth and Transparency in Pregnancy Counseling Centers H-420.954

“Our AMA supports that any entity offering crisis pregnancy services disclose information on site, in its advertising, and before any services are provided concerning the medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it provides; and be it further.”

2. Training in Reproductive Health Topics as a Requirement for Accreditation of Family Residencies D-310.954

“Our AMA: (1) will work with the Accreditation Council for Graduate Medical Education to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health including training in contraceptive counseling, family planning, and counseling for unintended pregnancy”

3. Access to Emergency Contraception D-75.997

“Our AMA will: (a) intensify efforts to improve awareness and understanding about the availability of emergency contraception in the general public”

4. Reducing Unintended Pregnancy H-75.987

“Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; (2) supports reducing unintended pregnancies as a national goal; and (3) supports the training of all primary care physicians and relevant allied health professionals in the area of preconception counseling, including the recognition of long-acting reversible contraceptives as efficacious and economical forms of contraception.”

5. AMA Principles for Physician Employment H-225.950

1. Addressing Conflicts of Interest

a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and

(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.

6. Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraceptive Placement H-75.984

“Our AMA: (a) recognizes the practice of immediate postpartum and post pregnancy long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies; and (b) supports the coverage by Medicaid, Medicare, and private insurers for immediate postpartum long-acting reversible contraception devices and placement, and that these be billed separately from the obstetrical global fee.”

7. Abortion H-5.995

Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician,

hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.

8. Policy on Abortion H-5.990

The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.

9. Increasing Transparency of Hospital Contracts for Clinical and Non-Clinical Services H-215.963

1. Our AMA encourage hospitals to publicly disclose the following parameters of their contracts for the delivery of clinical and non-clinical services:

- (a) The entity with which the hospital has contracted;
- (b) The ownership of the entity with which the hospital has contracted;
- (c) What services are being provided in accordance with the contract;
- (d) Which entity owners, if any, serve on any of the hospital's boards or its affiliates' boards; and
- (e) Whether the hospital requires exclusive physician referrals to hospital subsidiaries for services.

2. AMA policy is that the organized medical staffs have an opportunity to be involved in the selection of clinical and non-clinical service providers in hospitals with adherence to appropriate conflict of interest policies.

10. Price Transparency D-155.987

1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.

2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.

3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.

4. Our AMA will work with states to support and strengthen the development of all-payer claims databases.

5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.

6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.

7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

11. Accountable Care Organization Principles H-160.915

Our AMA adopts the following Accountable Care Organization (ACO) principles:

1. Guiding Principle - The goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient.

2. ACO Governance - ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician's medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients' interests first.

12. 270.022MSS Promoting Transparency to Stimulate Improved Quality

AMA-MSS will ask the AMA to encourage development of public and hospital-based reporting systems that create transparency into individual physician performance to stimulate quality improvement and better-informed patient and physician decision-making. (MSS Res 13, A-10) (AMA Policies Reaffirmed in Lieu of AMA Res 808, I-10) (Reaffirmed, MSS GC Rep D, I-15)

13. 75.005MSS Promotion of Emergency Contraception Pills

AMA-MSS will ask the AMA to: (1) support public health education relating to emergency contraception pills (ECPs) by working in conjunction with the appropriate specialty societies and organizations to encourage the widespread dissemination of information on ECPs to the medical community, women's groups, health groups, clinics, the public and the media; and (2) advocate programs that provide improved access to emergency contraception pills for women during after-hours need. (MSS Sub Res 54, I-98) (AMA Amended Res 403, A-99 Adopted [D-75.999]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I- AMA-MSS Digest of Policy Actions/ 14 08) (D-75.999 Rescinded: CSAPH Rep. 1, A-09) (Reaffirmed: GC Rep B, I-13)

14. 75.012MSS Recognizing Long-Acting Reversible Contraceptives (LARCs) as Efficacious and Economical Forms of Contraception

That our AMA (1) study unintended pregnancies and their consequences with a focus on current efficacious and economic methods to overcome the problem; and (2) support the training of all primary care providers in the area of preconception counseling. (MSS 30, A-14) (Reaffirmation A-15; Appended: Res. 502, A-15 Adopted with Change in Title [H-75.987])

15. 75.013 MSS Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraception Placement

AMA-MSS will ask (1) that our AMA recognize the practice of immediate postpartum and post-abortive long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies, (2) that our AMA support the coverage of immediate postpartum long-acting reversible contraception device and placement by Medicaid, Medicare, and private insurers, and that this service be billed separately from the obstetrical global fee, and (3) that our AMA encourage relevant specialty organizations to provide training for physicians regarding (i) patients who are eligible for immediate postpartum long-acting reversible contraception, and (ii) immediate postpartum long-active reversible contraception placement protocols and procedures. (MSS Res 10, I-15) (AMA Res 101, A-16 Adopted as Amended [])

16. 155.001MSS Listing of Hospital Charges:

AMA-MSS will ask the AMA to: (1) recommend that all hospitals accredited by the Joint Commission provide their medical students, housestaff, and attending physicians with a list of commonly ordered diagnostic tests and prescribed medications with their corresponding costs to patients; and (2) recommend that such charges be included on all reporting result sheets and requisition forms. (AMA Amended Res 75, I-81 Adopted [D-155.990]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Amended: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

17. 5.005 MSS MSS Stance on Challenges to Women’s Right to Reproductive Health Care Access

AMA-MSS opposes legislation that would restrict a woman’s right to obtain medical services associated with her reproductive health, as defined in policy 5.001 MSS, on the grounds that they interfere with a physician’s ability to provide medical care. (MSS Res 6, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS Res 27, A-16)

18. 5.001MSS Public Funding of Abortion Services

AMA-MSS will ask the AMA to: (1) continue its support of education and choice with respect to reproductive rights; (2) continue to actively support legislation recognizing abortion as a compensable service; and (3) continue opposition to legislative measures which interfere with medical decision making or deny full reproductive choice, including abortion, based on a patient's dependence on government funding. (AMA Sub Res 89, I-83, Adopted [H-5.998]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS Res 27, A-16)

19. 75.011MSS Informed Consent with Regards to Advertising and Prescribing Contraceptives

AMA-MSS: (1) supports continued research that explores alternative mechanisms of contraceptives; and (2) supports the concept of providing accurate and balanced information on the effectiveness, safety and risks/benefits of contraception in all public media and urges that such advertisements include appropriate information on the effectiveness, safety and risk/benefits of various methods with the addition of information regarding possible secondary mechanisms of contraceptive methods when conclusive and quantitative data is available. (MSS Rep B, A-04)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 14
(A-17)

Introduced by: Region 2; Region 7; Morehouse School of Medicine
Subject: Educating Physicians About the Importance of Cervical Cancer
Screening for Female-to-Male Transgender Patients
Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Cervical cancer screening is indicated for female-to-male transgender patients who
2 have a cervix and are sexually active, according to general cervical screening guidelines;¹ and
3
4 Whereas, Routine cervical screening has been shown to greatly reduce both the incidence of
5 new cervical cancers diagnosed each year and deaths from the disease;^{2, 3, 4} and
6
7 Whereas, Some health care providers incorrectly believe that female-to-male transgender
8 patients have a lower risk of cervical cancer;⁵ and
9
10 Whereas, A recent survey of obstetricians and gynecologists found that only 29% were
11 comfortable caring for female-to-male transgender patients;⁶
12
13 Whereas, Female-to-male transgender patients are significantly less likely to be up to date on
14 Pap smears than cisgender women;⁷ and
15
16 Whereas, Female-to-male transgender patients face barriers to adequate cervical cancer
17 screening, including lack of access to safe and inclusive health care providers and lack of
18 education on the importance of continuing to receive Pap smears;^{8, 9, 10, 11} and
19
20 Whereas, Even when receiving Pap smears, female-to-male transgender patients are
21 significantly more likely to have longer periods to test follow up from ambiguous lab results than
22 non-transgender patients;⁸ therefore be it

RESOLVED, That the AMA amend policy H-160.991 by addition and deletion as follows:

Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991

Our AMA will collaborate with our partner organizations to educate physicians regarding:
(i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) the need for regular cervical cancer

screening for female-to-male transgender patients when medically indicated and (iv) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases.

Fiscal note: TBD

Date received: 04/20/2017

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3. Committee on Practice Bulletins—Gynecology. Practice Bulletin No. 168: Cervical Cancer Screening and Prevention. *Obstet Gynecol* 2016; 128:e111.
4. Dickinson JA, Stankiewicz A, Popadiuk C, et al. Reduced cervical cancer incidence and mortality in Canada: national data from 1932 to 2006. *BMC Public Health* 2012;12:992.
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11. Dutton, L., Koenig, K., & Fennie, K. (2008). Gynecologic care of the female-to-male transgender man. *Journal of Midwifery & Women's Health*, 53(4), 331-337.

RELEVANT AMA AND AMA-MSS POLICY:

Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian gay bisexual and transgender (LGBT) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBT; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBT Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBT patients; (iii) encouraging the development of educational programs in LGBT Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBT people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBT communities to offer physicians the opportunity to better understand the medical needs of LGBT patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBT health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBT people.

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.

2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.

3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults,

(b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

**Screening and Education Programs for Breast and Cervical Cancer Risk Reduction
55.003MSS**

AMA-MSS will ask the AMA to (1) support programs to screen all women for breast and cervical cancer; (2) support government funded programs available for low income women; and (3) support the development of public information and educational programs with the goal of informing all women about routine cancer screening in order to reduce their risk of dying from cancer. (AMA Amended Res 418, I-91 Adopted [H-55.985]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (H-55.985 Rescinded: CCB/CLRPD Rep. 3, A-14)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 15
(A-17)

Introduced by: Connecticut

Subject: Patient and Physician Rights Regarding Immigration Status

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, On January 25, 2017 the President of the United States signed two executive orders
2 that significantly increased the number of undocumented immigrants targeted for deportation,
3 expanded the size and powers of U.S. Immigration and Customs Enforcement (ICE) and U.S.
4 Customs and Border Protection (CBP), and urged government “to employ all lawful means to
5 enforce the immigration laws of the United States”;^{1,2} and
6

7 Whereas, On February 20, 2017 the Secretary of the U.S. Department of Homeland Security
8 issued two memoranda implementing the President's January 25th executive orders;^{3,4} and
9

10 Whereas, No federal agency has released a public statement to clarify whether or not
11 information from medical records may be used for the purposes of immigration enforcement;
12 and
13

14 Whereas, Hospitals and physicians have expressed concern at the uncertain legislative
15 environment surrounding immigration enforcement and deportation;^{5,6} and
16

17 Whereas, Stringent immigration policies and the fear of deportation contribute to decreased use
18 of preventive health care and poorer health outcomes among undocumented patients;^{7,8,9,10,11}
19 and
20

21 Whereas, Recent literature published in major medical journals has called for physicians to
22 determine their patient's immigration status as a clinically significant aspect of their social
23 history;^{12,13} and
24

25 Whereas, Medical records have been used by researchers to determine patients' immigration
26 statuses, and thus may be viewed by immigration enforcement officials as a potential source of
27 a actionable information;¹⁴ and
28

29 Whereas, A “covered entity” is defined as “(1) A health plan. (2) A health care clearinghouse. (3)
30 A health care provider who transmits any health information in electronic form in connection with
31 a transaction covered [under 45 CFR Chapter A Subchapter C]”;¹⁵ and
32

33 Whereas, According to current HIPAA law: A covered entity may disclose some protected health
34 information in response to a law enforcement official's request for such information for the
35 purpose of identifying or locating a fugitive, suspect, material witness or missing person,
36 including name, address, date and place of birth;¹⁶ and
37

1 Whereas, A covered entity may disclose any protected health information to law enforcement
2 pursuant to a court order or court-ordered warrant, a subpoena or summons issued by a judicial
3 officer, a grand jury subpoena, or an administrative subpoena or summons under certain
4 conditions;¹⁷ and

5
6 Whereas, Current HIPAA law does not explicitly protect patient information from use by ICE,
7 CBP or other law enforcement for the purpose of immigration enforcement;¹⁸ and

8
9 Whereas, Current AMA policy strongly opposes any federal legislation requiring physicians to
10 establish the immigration status of their patients (H-270.961); and

11
12 Whereas, Current AMA policy opposes any policies, regulations, or legislation requiring
13 physicians and other health care providers to collect and report data regarding an individual
14 patient's legal resident status (H-440.876); and

15
16 Whereas, No AMA policy exists that addresses the disclosure of patient immigration status if
17 requested by federal authorities or access to medical records by federal authorities; and

18
19 Whereas, Prior to the President's January 25th Executive Orders, the Department of Homeland
20 Security stated that immigration enforcement actions by ICE or CBP may not take place at or in
21 "sensitive locations" which include hospitals, doctor's offices, accredited health clinics, and
22 emergent or urgent care clinics;^{19,20} and therefore be it

23
24 RESOLVED, That our AMA encourages the reaffirmation of federal guidelines on limitations of
25 enforcement actions by U.S. Immigration and Customs Enforcement and U.S. Customs and
26 Border Protection in the medical setting; and be it further

27
28 RESOLVED, That our AMA supports protections that prohibit U.S. Immigration and Customs
29 Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from
30 utilizing information from medical records to pursue immigration enforcement actions against
31 patients who are undocumented.

Fiscal Note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Financial Impact of Immigration on the American Health System H-160.920

Our AMA supports legislative and regulatory changes to require the federal government to make reasonable payments to physicians for the federally mandated care they provide to patients, regardless of the immigration status of the patient.

Medical Care Must Stay Confidential H-270.961

Our AMA will strongly oppose any federal legislation requiring physicians to establish the immigration status of their patients.

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876

1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively

and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.

Health Care Payment for Undocumented Persons D-440.985

Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.

Racial and Ethnic Disparities in Health Care H-350.974

Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

The AMA emphasizes three approaches that it believes should be given high priority:

(1) Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

(2) Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

(3) Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 16
(A-17)

Introduced by: Region 5; Pennsylvania Medical Society; University of Colorado School of
Medicine

Subject: Air Ambulance Regulations and Reimbursements

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Emergent air medical services are provided to critically-ill or injured patients to the
2 closest appropriate hospital via air ambulances when requested by third-party medical
3 professionals or first responders;¹ and
4

5 Whereas, Air ambulances improve access to level 1 trauma centers for 87 million Americans
6 who would not be able to receive emergent care in a timely manner otherwise with 86.4% of the
7 U.S. population living within a 15-to-20-minute response area of an air ambulance;¹ and
8

9 Whereas, The American College of Surgeons has published field triage guidelines yet 59% of
10 patients transported by air ambulance had minor injuries, as defined by an Injury Severity Score
11 of less than 15;² and
12

13 Whereas, The Airline Deregulation Act of 1978 prohibits states from regulating the price, route,
14 or service of an air carrier, including air ambulances, for the purposes of increasing competition,
15 reducing rates, and improving airline passenger service;³ and
16

17 Whereas, Since Medicare created a national fee schedule for air ambulances in 2002, more
18 than half of the air ambulance industry is now controlled by 4 for-profit operators with an
19 increase in air ambulances from 545 in 2002 to 1,045 in 2015;⁴ and
20

21 Whereas, Air Methods, the nation's largest air ambulance operator, has seen an increase in
22 their average bill of \$17,262 in 2009 to \$50,199 in 2016, far more than the actual cost for a flight
23 of only \$10,199;^{1,4} and
24

25 Whereas, Air Methods has resorted to hundreds of lawsuits against individuals throughout the
26 country seeking salary garnishment and other forms of debt collection;^{5,6} and
27

28 Whereas, Medicare only reimburses 59% of air ambulance costs, adding an average of \$15,984
29 to the cost of self-pay or privately insured patients as air ambulance operators recoup what they
30 lose on below-cost transports funded by the government;¹ and
31

32 Whereas, Private insurance companies that offer ambulance coverage only cover an average of
33 36.5% of the air ambulance's bill and, unlike Medicare and Medicaid, they are no regulations
34 preventing them from balance billing patients for charges after coverage has been applied; for
35 example, Blue Cross Blue Shield pays air ambulance companies \$13,780 plus \$89.72 per mile
36 and "balance bill" patients if the air ambulance company is out of network;⁷⁻⁹ and
37

1 Whereas, Between 2013 and 2016, insurance departments from nine states reviewed 55
2 incidences in which consumers complained of \$3.8 million in combined charges, an average
3 charge of \$70,000 per trip;¹⁰ and
4

5 Whereas, In 2015, the Maryland Insurance Administration held hearings to investigate a string
6 of consumer complaints regarding air ambulance bills ranging from \$20,000 to over \$40,000;¹¹
7 and
8

9 Whereas, Laws from Wyoming seeking to cap air ambulance fees and North Dakota forcing air
10 ambulance companies to become participating providers by joining major insurance company
11 networks have been struck down in federal courts;¹² therefore be it
12

13 RESOLVED, That our AMA study the role, clinical efficacy, and cost-effectiveness of air
14 ambulance services, including barriers to adequate competition, reimbursement, and quality
15 improvement.

Fiscal Note: TBD

Date Received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Non-Emergency Patient Transportation Systems H-130.954

The AMA: (1) supports the education of physicians and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

Protection of Insurance Coverage for Medical Attendants Aboard Non-Scheduled Aircraft H-45.986

Our AMA supports seeking appropriate action, including legislation if necessary, which would result in an exemption or exception to the exclusion of benefits clauses of insurance policies for all medical care providers and others when they are participating in medical aircraft flights, even though such flights might otherwise be considered as "non-scheduled." (AMA Res 144, A-91)

Medicare's Ambulance Service Regulations H-240.978

The AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to facilities other than the closest based upon the physician's judgment. (AMA Res 37, A-88)

Emergent Care Adjacent to Hospitals H-215.973

The AMA will urge hospitals and their medical staffs to review their policy that pertains to the administration of care to critically ill patients who present adjacent to hospitals without ambulance assistance. (AMA Res 859, A-98)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 17
(A-17)

Introduced by: Briana Vamosi, Roxanne Rezaei, University of Cincinnati College of Medicine
Subject: Addressing Foster Care Healthcare Needs
Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Over 400,000 children were within the foster care system, including 269,509 new
2 entries, according to the most recent data from the U.S. Department of Health & Human
3 Services;¹ and
4
5 Whereas, In a 2014 study, 48.3% of children within the foster care system experience four or
6 more adverse family experiences. These traumatic experiences lead to and include being
7 removed from one's home,² and,
8
9 Whereas, Adults who had a history of being in the foster care system had significantly higher
10 rates than the general population of posttraumatic stress disorder and toxic stress related
11 symptoms such as attachment disorders, affect dysregulation, and behavior control issues,³⁻⁴
12 and,
13
14 Whereas, Toxic stress and childhood trauma can impact a child's immune system,
15 neurodevelopment, and genome resulting in delays in cognitive, behavioral, and physical
16 development,^{3,5-7} and,
17
18 Whereas, Toxic stress and childhood trauma can lead to poor health outcomes into adulthood
19 such as alcoholism, chronic obstructive pulmonary disease, depression, cancer, obesity,
20 increase in suicide attempts, and ischemic heart disease,³ and,
21
22 Whereas, Children within the foster system face unique legal and social barriers including
23 limited healthcare records, the need to identify who can consent to care for the child, court
24 mandated treatments, and limited resources;⁸⁻¹¹ and,
25
26 Whereas, Screenings, Screenings, such as Ages and Stages Questionnaire for developmental
27 delays can increase detection by 29% and earlier intervention;¹² and,
28
29 Whereas, the American Academy of Pediatrics identifies fifteen Models of Care which can be
30 used for further creation of foster care clinics,¹³ and,
31
32 Whereas, Existing foster care clinics, while limited in number, provide coordination of care,
33 screenings regarding normal development, and transition support for the child and foster
34 families;¹³⁻¹⁴ therefore be it,
35
36 RESOLVED, That our American Medical Association (AMA) advocate for comprehensive, trauma-
37 informed care to address special health care needs of foster care children;

- 1 RESOLVED, That our American Medical Association advocate for evidence-based clinical and
2 policy interventions to prevent, diagnose, and address childhood trauma and toxic stress.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Child Protection Legislation H-60.948

The AMA opposes legislation that would: (1) hinder, obstruct or weaken investigations of suspected child and adolescent abuse, and (2) hamper or interfere with child protection statutes. Sub. Res. 219, I-97; Reaffirmed: BOT Rep. 33, A-07

Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse D-515.982

Our AMA will work with members of the Federation of Medicine and other appropriate organizations to educate physicians on (1) the relationship between domestic violence and child abuse and (2) the appropriate role of the physician in treating patients when domestic violence and/or child abuse are suspected. Res. 415, A-09

Evidence of Standards for Child Sexual Abuse H-515.989

The AMA continues to support the standardization of evidence in child sexual abuse cases and urges that examination and treatment of child abuse victims be done by a physician. Res. 78, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07

American Medical Association
Medical Student Section

Resolution 18
(A-17)

Introduced by: Pauline Huynh, Pranjal Gupta, Pooja Yesantharao, Johns Hopkins
University School of Medicine

Subject: Amendment of AMA-MSS Cannabis Policy

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1
2 Whereas, 28 states and Washington D.C. have legalized cannabis for medicinal use,¹ with 8
3 states and Washington D.C. also legalizing cannabis for recreational use,² and
4

5 Whereas, U.S. public support for cannabis legalization continues to increase, becoming the
6 majority opinion in 2013,³⁻⁴ with recent polls citing that up to 60% of Americans support full
7 legalization⁵⁻⁶ and up to 93% support legalization for medical use;⁷ and
8

9 Whereas, Despite supporting increased education, research, and “immunity from federal
10 persecution for physicians [who recommend] cannabis” for medicinal purposes, the AMA
11 explicitly opposes the legalization of cannabis and endorses warnings describing high risk of
12 abuse and misuse (AMA Policies H-95.952, H-95.938, and D-95.976); and
13

14 Whereas, A systematic review by the National Academies of Sciences, Engineering, and
15 Medicine analyzed over 10,000 abstracts and concluded medicinal cannabis to be effective in
16 the treatment of chronic back pain, chemotherapeutic-induced nausea and vomiting, and
17 symptoms of multiple sclerosis;⁸ and
18

19 Whereas, The U.S. Food and Drug Administration has approved dronabinol and nabilone, both
20 synthetic cannabinoids mimicking the tetrahydrocannabinol found in cannabis, for
21 chemotherapeutic-induced nausea and vomiting;⁹⁻¹⁰ and
22

23 Whereas, Consumers of medicinal cannabis do appear to consume cannabis in attempts to
24 address legitimate medical and mental health concerns;¹¹⁻¹³ and
25

26 Whereas, Medical usage of cannabis is associated with reduced opioid pain reliever (OPR)-
27 related hospitalizations¹⁴⁻¹⁵ and OPR overdose mortality,¹⁶ without an increase in cannabis-
28 related hospitalization¹⁴ or cannabis potency;¹⁷ and
29

30 Whereas, Association studies between respiratory malignancies/chronic obstructive pulmonary
31 disease and cannabis use are inconclusive and research shows that habitual use of cannabis
32 does not significantly alter pulmonary function,¹⁸⁻²⁰ while clinical trials link cannabis use to
33 increased airway conduction;²¹ and
34

35 Whereas, Research shows that more than 50% of medical cannabis users have tried alternative
36 routes of cannabis administration that are not linked to respiratory illness but provide therapeutic
37 effect (vaporization, oral, and topical preparations),²²⁻²⁴ and studies have found vaporizer use to
38 be the most popular method of administration for medical cannabis, with vaporizer use on the

1 rise;²⁵ and

2

3 Whereas, Research finds cannabis usage to be associated with impairment of cognitive-motor
4 skills within 2 hours of smoking²⁶⁻²⁷ and an increase in motor vehicle collisions shortly after
5 statewide legalization of cannabis before plateauing;²⁷⁻²⁸ and

6

7 Whereas, Despite this research, drivers under the influence of natural cannabis are less likely to
8 exhibit confusion, incoherence, and driving impairment compared to drivers under the influence
9 of synthetic cannabinoids;²⁹ and

10

11 Whereas, Research indicates that that the lifetime dependence risk for cannabis is 9%, as
12 compared to 32% for nicotine, 23% for heroin, 17% for cocaine and 15% for alcohol;³⁰ and
13 Whereas, Data show that from the period of 1995-1999, surrounding the 1996 legalization of
14 medicinal cannabis through Proposition 215 in California, although the perceived risk of
15 cannabis significantly decreased and the perceived availability of cannabis significantly
16 increased in youths and young adults, the actual use of cannabis did not significantly differ;³¹
17 and

18

19 Whereas, Resolution 907 at AMA I-16, which opposed current AMA policy H-95.998 stating that
20 the sale of cannabis should not be legalized, was referred for further study with a pending report
21 from the AMA CSAPH; and

22

23 Whereas, AMA-MSS supports the abolition of “all criminal penalties relating to the consumption
24 and possession of cannabis” but has no official stance on the legalization of cannabis
25 (95.008MSS); therefore be it

26

27 RESOLVED, That our AMA-MSS include amend policy 95.008MSS to include its position by
28 insertion as follows:

29

30 **95.008MSS Cannabis and the Regulatory Void**

31

32 AMA-MSS believes that although cannabis is a mind-altering drug whose use may have
33 unforeseen consequences; (1) federal and state governments should abolish all criminal
34 penalties relating to consumption or possession of cannabis; (2) the regulated sale of
35 cannabis for medicinal use should be supported; and (3) additional research should be
36 encouraged.

37

Fiscal Note: TBD

Date Received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Cannabis – Expanded AMA Policy D-95.976

(1) Our AMA will educate the media and legislators as to the health effects of cannabis use as elucidated in CSAPH Report 2, I-13, A Contemporary View of National Drug Control Policy, and CSAPH Report 3, I-09, Use of Cannabis for Medicinal Purposes, and as additional scientific evidence becomes available. (2) Our AMA urges legislatures to delay initiating full legalization of any cannabis product until further research is completed on the public health, medical, economic and social consequences of use of cannabis and, instead, support the expansion of such research. (3) Our AMA will also increase its efforts to educate the press, legislators and the public regarding its policy position that stresses a "public health", as contrasted with a "criminal," approach to cannabis. (4) Our AMA shall encourage model legislation that would require placing the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States." (Res. 213, I-14)

Cannabis Warnings for Pregnant and Breastfeeding Women H-95.936

Our AMA advocates for regulations requiring point-of-sale warnings and product labeling for cannabis and cannabis-based products regarding the potential dangers of use during pregnancy and breastfeeding wherever these products are sold or distributed. (Res 922, I-15)

Immunity from Federal Persecution for Physicians Recommending Cannabis H-95.938

Our American Medical Association supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws. (Res. 233, A-15)

Cannabis for Medicinal Use H-95.952

(1) Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. (2) Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product. (3) Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug

Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support. (4) Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. (CSA Rep. 10, I-97; modified: CSA Rep. 6, A-01; modified: CSAPH Rep. 3, I-09; modified in lieu of Res. 902, I-10; reaffirmed in lieu of Res. 523, A-11; Reaffirmed in lieu of Res. 202, I-12; reaffirmed: CSAPH Rep. 2, I-13)

Cannabis Use H-95.995

Our AMA (1) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk situations; (2) supports the determination of the consequences of long-term cannabis use through concentrated research, especially among youth and adolescents; and (3) supports the modification of state and federal laws to emphasize public health based strategies to address and reduce cannabis use. (CSA Rep. D, I-77; reaffirmed: CLRPD Rep. C, A-89; reaffirmed: Sunset Report, A-00; reaffirmed: CSAPH Rep. 1, A-10; modified: CSAPH Rep. 2, I-13)

Cannabis Intoxication as a Criminal Defense H-95.997

Our AMA believes a plea of cannabis intoxication not be a defense in any criminal proceedings. (BOT Rep. J, A-72 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report, A-00 Reaffirmed: CSAPH Rep. 1, A-10 Modified: CSAPH Rep. 2, I-13)

AMA Policy Statement on Cannabis H-95.998

Our AMA believes that (1) cannabis is a dangerous drug and as such is a public health concern; (2) sale of cannabis should not be legalized; (3) public health based strategies, rather than incarceration, should be utilized in the handling of individuals possessing cannabis for personal use; and (4) additional research should be encouraged. (BOT Rep. K, I-69; reaffirmed CLRPD Rep. C, A-89; reaffirmed Sunset Report, A-00; reaffirmed CSAPH Rep. 1, A-10; reaffirmed in lieu of Res. 202, I-12; modified CSAPH Rep. 2, I-13)

95.003MSS Marijuana: Medical Use and Research

AMA-MSS will ask the AMA to support reclassification of marijuana's status as a Schedule I controlled substance into a more appropriate schedule. (MSS Res 2, A-08) (AMA Res 910, I-08 Referred) (Reaffirmed: GC Rep B, I-13)

95.008MSS Cannabis and the Regulatory Void

AMA-MSS believes that although cannabis is a mind-altering drug whose use may have unforeseen consequences; (1) federal and state governments should abolish all criminal penalties relating to consumption or possession of cannabis; and (2) additional research should be encouraged. (MSS Res 27, I-12)

95.009MSS Addressing Emerging Trends in Recreational Drug Abuse

That our AMA (1) support the appropriate agency to provide continuing medical education courses in emerging trends in recreational substance abuse; and (2) support the appropriate agency to disseminate current and accurate information regarding emerging trends in recreational substance abuse. (MSS Res 16, A-14) (Substitute AMA Res 901, I-14 Adopted with Change in Title [H-95.940])

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 19
(A-17)

Introduced by: Region 7; Trevor Cline, UC Davis School of Medicine
Subject: Human Rights as the Foundation of Public Health
Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, The United States of America voted in favor of the United Nations General
2 Assembly's Universal Declaration of Human Rights (UDHR) in 1948, and ratified each
3 amending covenant that together constitute the encompassing International Bill of Human
4 Rights;^{1,2} and
5
6 Whereas, Article 25 of the UDHR states that "everyone has the right to a standard of living
7 adequate for the health and well-being of himself and of his family, including...medical care";^{1,2}
8 and
9
10 Whereas, The United States is also a member state of the World Health Organization (WHO)
11 and its attendant World Health Assembly (WHA), which exhort all member states to "contribute
12 to meeting the needs of the population for health care";³ and
13
14 Whereas, The United States makes good on these promises via Medicare and Medicaid
15 programs, the National Institutes of Health, the Center for Disease Control and Prevention,
16 emergency services offerings regardless of ability to pay, and state-level provisions for good
17 samaritans in addition to participation in global health efforts;^{4,5,6} and
18
19 Whereas, The 115th Congress of the United States has proposed to withdraw the United States
20 from both the United Nations and the World Health Organization, potentially undermining these
21 commitments;⁷ and
22
23 Whereas, Our AMA has repeatedly endorsed the World Medical Association's Declaration of
24 Tokyo, which amongst other principles establishes that "The physician's fundamental role is to
25 alleviate the distress of his or her fellow human beings, and no motive, whether personal,
26 collective or political, shall prevail against this higher purpose"(H-65.997, H-65.991);⁸ and
27
28 Whereas, The WMA Declaration of Tokyo further encourages lifelong education on and
29 furtherance of human rights by physicians and calls on all national medical associations to
30 promote these endeavors;⁸ and
31
32 Whereas, Our AMA recognizes that its conduct serves a model for health organizations around
33 the globe, and that participation in these organizations is essential to achieving the AMA's goals
34 for public health, both domestic and international (G-630.070); and
35

1 Whereas, Our AMA supports continued funding of the World Health Organization and
2 participation in international medical organizations (H-250.986, H-250.999, H-250.992); and
3
4 Whereas, Our AMA has codified a physician's duty to care for, advocate on behalf of, and
5 endeavor to improve future care for all persons, making no exceptions for gender,
6 socioeconomic status, race, origin, or creed (ex. H-140.900, H-140.997, H-140.838, H-160.975,
7 H-140.951); and
8
9 Whereas, Our AMA and others recognize socioeconomic factors and self determination as
10 important components of an individual's health as well as public health (ex. H-295.874);^{9, 10, 11}
11 and
12
13 Whereas, Our AMA has written extensive policy in support of the individual rights outlined by the
14 UN UDHR, including nondiscrimination, freedom from persecution or torture, protection from
15 slander, broad access to scientific advancements, education, reasonable working hours, and
16 others (ex. H-140.900, H-65.965, H-65.997, D-478.980, H-460.973); and
17
18 Whereas, Our AMA has not yet specifically named healthcare as one such right; and
19
20 Whereas, Our AMA restricts its equal pay for equal work policy to geographic disparities (D-
21 390.989, D-400.989); and
22
23 Whereas, Our AMA recognizes the vulnerability of refugee patients and physicians, but not the
24 right of these individuals to seek asylum (H-350.957, H-200.950); and
25
26 Whereas, Our AMA supports respectful interactions with patients and sets guidelines for email
27 communications, but only has policy covering libel or slander against physicians or third parties,
28 not patients (D-478.980, H-478.997); and
29
30 Whereas, Our AMA has policy supporting adequate healthcare in detention facilities and
31 segregation of juvenile from adult prisoners, but does not currently address the individual and
32 community effects of wrongful imprisonment outside of the juvenile population (H-160.916, H-
33 430.997, H-60.987, H-60.919); and
34
35 Whereas, Each of the above gaps in current AMA policy is addressed by the 1948 UDHR;
36 therefore be it
37
38 RESOLVED, That our AMA endorses the United Nations General Assembly's 1948 Universal
39 Declaration of Human Rights as guiding principles fundamental to the betterment of public
40 health; and be it further
41
42 RESOLVED That our AMA-MSS reaffirms policy H-250.993 and requests that our AMA will
43 advocate for the United States to remain a member state in the World Health Organization.
44

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Human Rights H-65.997

Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.

Persecution of Physicians for Political Reasons and Participation by Doctors in Violations of Human Rights H-65.991

The AMA (1) reiterates its endorsement of the 1975 World Medical Association Declaration of Tokyo which provides guidelines for physicians in cases of torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment; (2) opposes participation by physicians in the torture or inhuman treatment or punishment of individuals in relation to detention and imprisonment; and (3) expresses its sympathy to those physicians who

have been subject to imprisonment or torture because of their humanitarian efforts to improve the health of their patients.

International Strategy G-630.070

Our AMA recognizes the importance of the involvement of the medical profession in this country in influencing the standards utilized by other nations with regard to ethics, medical education and medical practice, and the commitment to the patient-physician relationship.

AMA and Public Health in Developing Countries H-250.986

Our AMA will adhere to a focused strategy that channels and leverages our reach into the global health community, primarily through participation in the World Medical Association and the World Health Organization.

World Health Organization H-250.999

Our AMA supports the position of the U.S. government to preserve the integrity of the World Health Organization (WHO) and opposes any attempts to politicize the WHO.

World Health Organization H-250.992

The AMA: (1) continues to support the World Health Organization as an institution; (2) advocates full funding as understood by the United States Government for the World Health Organization; (3) will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization; and (4) encourages the World Medical Association to develop a cooperative work plan with the World Health Organization as expeditiously as possible.

Collaborative Care H-140.838

In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, protecting the integrity of the patient-physician relationship, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members. An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As leaders within health care teams, physicians individually should:

(a) Model ethical leadership by: (i) understanding the range of their own and other team members' skills and expertise and roles in the patient's care; (ii) clearly articulating individual responsibilities and accountability; (iii) encouraging insights from other members and being open to adopting them; and (iv) mastering broad teamwork skills.

- (b) Promote core team values of honesty, discipline, creativity, humility, and curiosity and commitment to continuous improvement.
 - (c) Help clarify expectations to support systematic, transparent decision making.
 - (d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member's opinion is heard and considered and team members share accountability for decisions and outcomes.
 - (e) Communicate appropriately with the patient and family and respect their unique relationship as members of the team.
- As leaders within health care institutions, physicians individually and collectively should:
- (f) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.
 - (g) Encourage their institutions to identify and constructively address barriers to effective collaboration.
 - (h) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.

A Declaration of Professional Responsibility H-140.900

Our AMA adopts the Declaration of Professional Responsibility

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

Preamble

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

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

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to: (1)
Respect human life and the dignity of every individual.

(2) Refrain from supporting or committing crimes against humanity and condemn any such acts.

(3) Treat the sick and injured with competence and compassion and without prejudice.

- 1 (4) Apply our knowledge and skills when needed, though doing so may put us at risk.
2
3 (5) Protect the privacy and confidentiality of those for whom we care and breach that confidence
4 only when keeping it would seriously threaten their health and safety or that of others.
5
6 (6) Work freely with colleagues to discover, develop, and promote advances in medicine and
7 public health that ameliorate suffering and contribute to human well-being.
8
9 (7) Educate the public and polity about present and future threats to the health of humanity.
10
11 (8) Advocate for social, economic, educational, and political changes that ameliorate suffering
12 and contribute to human well-being.
13
14 (9) Teach and mentor those who follow us for they are the future of our caring profession.

15
16 We make these promises solemnly, freely, and upon our personal and professional honor.
17
18

19 **Professionalism and Medical Ethics H-140.951**

20 The AMA reaffirms that the medical profession is solely responsible for establishing and
21 maintaining standards of professional medical ethics and that the state cannot legislate ethical
22 standards or excuse physicians from their ethical obligations; and urges all physicians and other
23 appropriate health professional organizations to make their views known to their state
24 legislatures and governors.
25
26

27 **Patient Advocacy H-140.997**

28 Our AMA believes that physicians are the primary patient advocates, are not rationers of
29 medical care, and will continue to utilize diagnostic and therapeutic measures and facilities in
30 the best interest of the individual patient.
31
32

33 **Planning and Delivery of Health Care Services H-160.975**

34 (1) Planning agencies should utilize policies, educational programs and incentives to develop
35 and maintain individual lifestyles that promote good health. The planning process should identify
36 incentives for the providers and participants in the health care system to encourage the
37 development and introduction of innovative and cost-effective health care services. Government
38 at all levels, as a provider, purchaser and consumer of health services, should play an integral
39 role in the planning process, including the provision of adequate funding and ensuring that
40 government policies and/or regulations facilitate and do not unduly restrict the planning process.
41 The authority to impose sanctions on those who take actions that are inconsistent with
42 developed plans should be separated from the planning process. Funding for the planning
43 process should be developed by the participants.
44

45 (2) The planning process should seek to ensure the availability and the coordination of a
46 continuum of supportive health care services for special populations in senior citizen centers,
47 day care and home care programs, supervised life-care centers, nursing homes, hospitals,
48 hospices, and rehabilitation facilities.
49

(3) Decisions concerning the use of health care services, including the selection of a health care provider or delivery mechanism, should be made by the individual.

(4) Both the public and private sectors should be encouraged to donate resources to improve access to health care services. Where appropriate, incentives should be provided for those in the private sector who give care to those who otherwise would not have access to such care. In addition, existing short-comings in the current public system for providing access need to be addressed.

(5) Health care facilities should have or should establish review bodies (such as hospital ethics committees) to resolve conflicts over access to scarce health care technologies. In the event that a conflict over delivery of scarce health care technologies cannot be mediated satisfactorily, individuals should be able to seek redress through appropriate appeal mechanisms.

AMA Principles for Physician Employment H-225.950

1. Addressing Conflicts of Interest

a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and

(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.

e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine

and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession

a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

- a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
- b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
- c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
- d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
- e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
- (f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
 - i. The agreement is for the provision of services on an exclusive basis; and
 - ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
 - iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

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.

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through

letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Policies for Parental, Family, and Medical Necessity Leave H-405.960

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or

gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

Anonymous Cyberspace Evaluations of Physicians D-478.980

Our AMA will: (1) work with appropriate entities to encourage the adoption of guidelines and standards consistent with AMA policy governing the public release and accurate use of physician data; (2) continue pursuing initiatives to identify and offer tools to physicians that allow them to manage their online profile and presence; (3) seek legislation that supports the creation of laws to better protect physicians from cyber-libel, cyber-slander, cyber-bullying and the dissemination of Internet misinformation and provides for civil remedies and criminal sanctions for the violation of such laws; and (4) work to secure legislation that would require that the Web sites purporting to offer evaluations of physicians state prominently on their Web sites whether or not they are officially endorsed, approved or sanctioned by any medical regulatory agency or authority or organized medical association including a state medical licensing agency, state Department of Health or Medical Board, and whether or not they are a for-profit independent business and have or have not substantiated the authenticity of individuals completing their surveys.

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. 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 e-mail 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.

Protection of Scientific Freedom from Special Interest Groups H-460.973

The AMA reaffirms that the principles of scientific freedom for individual investigators should be upheld by all research funding agencies, administrators, and professional societies.

Equal Pay for Equal Work D-390.989

Our AMA will work to eliminate the unfairness inherent in the current wide geographic disparity in physician Medicare reimbursement.

Equal Pay for Equal Work D-400.989

Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and (3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.

Retraining Refugee Physicians H-200.950

Our AMA supports federal programs, and funding for such programs, that assist refugee physicians who wish to enter the US physician workforce, especially in specialties experiencing shortages and in underserved geographical areas in the US and its territories.

Addressing Immigrant Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 20
(A-17)

Introduced by: Region 2

Subject: Decreasing Screen Time and Increasing Outdoor Activity to Offset Myopia Onset and Progression in Elementary School Children

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Myopia is increasing among children worldwide, remains the leading cause of visual
2 impairment globally, will likely affect 50% of the world's population by 2050, may lead to a lower
3 quality of life, may cause an increased financial burden due to an earlier onset of myopia in
4 children, and increasing time spent outdoors and decreasing screen time may reduce myopia
5 incidence or slow progression;^{1, 2, 3, 4, 5} and
6

7 Whereas, The post-millennial generation spends nearly 8 hours/day staring at electronic
8 screens, and the shift towards doing near activity raises the likelihood of developing myopia,
9 and screen time takes away from outdoor activity, physical activity, and face-to-face social
10 interaction in the real world;^{6, 7, 8} and
11

12 Whereas, Numerous studies confirm the associations of myopia progression with longer time
13 spent for near work >45min, shorter near work distance <20cm, and close television viewing
14 distance <3m, recommending that schools increase outdoor activity time during class recess to
15 help reduce the development and progression of myopia in children and adolescents;^{5, 7, 9} and
16

17 Whereas, A disruption in circadian rhythm may lead to myopia, calling for the need of decreased
18 screen time especially at night and increased outdoor activity during the day;¹⁰ and
19

20 Whereas, A randomized controlled trial done in 12 primary schools in China added 40 minutes
21 of outdoor activity over a period of three years and resulted in a reduced myopic incidence rate
22 by 9.1%, and a meta-analysis pooled together 7 cross-sectional studies and found a 2%
23 reduced odds of myopia per additional hour of time spent outdoors per week;^{4, 8} therefore be it
24

25 RESOLVED, That our AMA-MSS supports physicians, schools, and public health agencies in
26 efforts to reduce the incidence and progression of myopia by limiting screen time and increasing
27 outdoor activity among elementary school children.

Fiscal note: TBD

Date Received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Encouraging Vision Screenings for Schoolchildren H-425.977

Our AMA: (1) encourages and supports outreach efforts to provide vision screenings for school-age children prior to primary school enrollment; (2) encourages the development of programs to improve school readiness by detecting undiagnosed vision problems; and (3) supports periodic

pediatric eye screenings based on evidence-based guidelines with referral to an ophthalmologist for a comprehensive professional evaluation as appropriate.

440.006MSS Ocular Sun Damage to the Retina and its Prevention:

AMA-MSS will ask the AMA to: (1) support efforts to educate the general public about the potential long term effects of sun and bright light exposure, and the possible benefit derived from wearing protective eye wear blocking out radiation of wavelengths of less than 500nm in preventing AMA; and (2) incorporate this issue into existing health education efforts. (AMA Res 12, A-91 Referred) (BOT Rep T, I-91 Filed) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

60.010MSS Encouraging Vision Screenings for Schoolchildren:

AMA-MSS will ask the AMA to: (1) encourage and support outreach efforts to provide vision screenings for school-age children prior to primary school enrollment and (2) encourage the development of programs to improve school readiness by detecting undiagnosed vision problems and support periodic pediatric eye screenings with referral for comprehensive professional evaluation as appropriate. (MSS Res 15, A-04) (AMA Amended Res 430, A-05 Adopted [H-425.977]) (Reaffirmed: MSS Res 53, A-15)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 21
(A-17)

Introduced by: Region 1; Region 3; Region 4; Region 5; Region 7

Subject: Sexual Assault Survivors' Rights

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Sexual violence is defined as a sexual act that is committed or attempted by another
2 person without freely given consent of the victim or against someone who is unable to consent
3 or refuse;¹ and
4

5 Whereas, Sexual assault is defined as any type of sexual contact or behavior that occurs
6 without the explicit consent of the recipient;⁶ and
7

8 Whereas, Sexual violence has serious consequences on physical, mental, sexual and
9 reproductive health;^{2,3} and
10

11 Whereas, 1 in 5 women and 1 in 59 men have experienced completed or attempted rape, 25
12 million Americans are rape survivors, and 431,837 people reported rape or sexual assault in the
13 United States in 2015, amounting to about 49 sexual assaults per hour;^{1,4,5,7} and
14

15 Whereas, A sexual assault medical forensic exam is an examination conducted by a health care
16 provider which includes gathering the medical forensic history, treating injuries, documenting
17 biological/physical evidence findings, administering a sexual assault evidence collection kit for
18 evidence collection, and providing treatment information for STIs, pregnancy, suicidal ideation,
19 alcohol and substance abuse;⁸ and
20

21 Whereas, Rape has been reported as the crime having the highest lifetime cost to the victim
22 and it has been estimated that each rape costs approximately \$151,423;^{17,18} and
23

24 Whereas, The Violence Against Women Reauthorization Act of 2013 requires state, tribal and
25 local governments to offer medical forensic examinations to victims of sexual assault without
26 regard to whether the victim participates in the criminal justice system or cooperates with law
27 enforcement;^{9,10} and
28

29 Whereas, Medical forensic examinations must be provided at no cost to the victim, with federal
30 reimbursement for costs incurred by state, tribal and local governments under the STOP
31 Violence Against Women Formula Grant Program;^{8,9,10} and
32

33 Whereas, Sexual assault evidence collection kit storage policies vary across jurisdictions,
34 resulting in some kits being discarded in as little as 30 days or kits being discarded before the
35 state-specific statute of limitations which can expire in as little as 3 years;^{8,11,18,19} and
36

1 Whereas, Requiring sexual assault survivors to repeatedly request extensions for the
2 preservation of their kits, especially if they remain undecided about pursuing legal action, places
3 an undue burden on the survivor with consequences to their mental health and recovery;^{8,11} and
4

5 Whereas, Sexual assault survivors are sometimes given no information about the testing,
6 results, or destruction of their kits;^{11,22,23} and
7

8 Whereas, Some states do not guarantee that all legal rights of a crime victim will be protected
9 for sexual assault survivors;^{11,19,23,24,25,26,27} and
10

11 Whereas, An inconsistent patchwork of state laws has resulted in sexual assault survivors
12 sometimes being charged for their own evidence collection kit or associated treatments;^{11,20,21}
13 and
14

15 Whereas, Sexual assault survivors are sometimes not informed about their legal options;^{11,28,29}
16 and
17

18 Whereas, The federal Survivors' Bill of Rights Act of 2016 (SBRA) was passed by Congress and
19 signed into law to address these challenges faced by sexual assault survivors;^{13,14} and
20

21 Whereas, SBRA establishes that a survivor of sexual assault has the right to receive a medical
22 forensic examination at no cost, that the evidence collection kit be preserved, without charge,
23 for the duration of the statute of limitations or 20 years, that the survivor be informed of the
24 results of the kit, that the survivor be notified of plans to destroy the kit, that the survivor be
25 granted further preservation of the kit if requested, and that the survivor be informed of these
26 rights;^{13,14} and
27

28 Whereas, The Federal government is limited in its ability to change law enforcement practices at
29 the State level and since the provisions of SBRA involve elements of law enforcement, adopting
30 the federal standards set by SBRA can only be accomplished by individual State legislation;¹⁵
31 and
32

33 Whereas, Five states (MA, WA, VA, OR, MD) have passed legislation similar to the Survivors'
34 Bill of Rights Act of 2016, five additional states (VT, CA, MN, OK, WV) have introduced similar
35 legislation, and twenty one states have ongoing advocacy efforts to consider similar
36 legislation;¹² and
37

38 Whereas, All citizens should have an opportunity to avail themselves of these crucial rights; and
39

40 Whereas, SBRA instructs the Attorney General and the Secretary of Health and Human
41 Services to establish a joint working group, including the medical provider community, to
42 develop, coordinate, disseminate and encourage implementation of best practices regarding the
43 care of sexual assault survivors and the preservation of evidence among hospital
44 administrators, physicians, forensic examiners, medical community leaders, and medical
45 associations;^{13,14} and
46

47 Whereas, Existing AMA policy supports rape victim services and the dissemination of
48 information to practicing providers on caring for rape victims, but does not specifically address
49 the medical-legal rights of sexual assault survivors or the need for collaboration between the
50 medical and legal communities in addressing this pressing public health issue; therefore be it
51

1 RESOLVED, That our AMA publicly recognizes sexual violence as a serious social and public
2 health issue of epidemic proportions which must be addressed through the concerted actions of
3 the medical and legal communities; and be it further
4

5 RESOLVED, That our AMA advocates for the legal protection of sexual assault survivors' rights
6 and will work with state medical societies to ensure that each state implements these rights,
7 which include but are not limited to, the right to:
8

9 (1) receive a medical forensic examination free of charge, which includes but is not be limited to
10 HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of
11 forensic evidence;

12 (2) preservation of a sexual assault evidence collection kit for at least the maximum applicable
13 statute of limitation;

14 (3) notification of any intended disposal of a sexual assault evidence kit with the opportunity to
15 be granted further preservation;

16 (4) be informed of these rights and the policies governing the sexual assault evidence kit; and
17 be it further
18

19 RESOLVED, That our AMA collaborate with relevant stakeholders to develop recommendations
20 for implementing best practices in the treatment of sexual assault survivors, including through
21 engagement with the joint working group established for this purpose under the Survivor's Bill of
22 Rights Act of 2016.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

H-515.979 Violence as a Public Health Issue

The AMA reaffirms and expands current policy by (a) declaring violence in America to be a major public health crisis; and (b) supporting research into the causes of violent behavior and appropriate interventions which may result in its prevention or cure. (Sub. Res. 408, I-92; Amended: CSA Rep. 8, A-03; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 1, A-13)

H-80.999 Rape Victims

Our AMA supports the preparation and dissemination of information intended to maintain and improve the skills needed by all practicing physicians involved in providing care to rape victims.

H-80.998 Rape Victim Services

The AMA supports the function and efficacy of rape victim services, encourages rape crisis centers to continue working with local police to help rape victims, and encourages physicians to support the option of having a rape victim counselor present while the victim is receiving medical care.

D-515.993 Support for Legislative Action and Improved Research on the Health Response to Violence and Abuse

Our AMA, in conjunction with other members of the Federation and the National Advisory Council on Violence and Abuse will: (1) identify and actively support state and federal legislative proposals designed to increase scientific knowledge, promote public and professional awareness, enhance recognition and ensure access to appropriate medical services for patients who have experienced violence and/or abuse; (2) actively support legislation and congressional authorizations designed to increase the nation's health care infrastructure addressing violence and abuse including proposals like the Health CARES (Child Abuse Research, Education and Services) Network; (3) actively support expanded funding for research on the primary prevention of violence and abuse, the cost of violence and abuse to the health care system, and

the efficacy of interventions and methods utilized in the identification and treatment of victims of violence and abuse; (4) actively study the best practices in diagnosis and management of family violence (including an analysis of studies not reviewed in the recent US Preventive Services Task Force Recommendations on Screening for Family Violence) and present a report that identifies future research and practice recommendations; and (5) invite a Federation-wide task force to review and promote the best practices in the identification, management and prevention of family violence. (Res. 438, A-04)

H-80.994 Use of all Appropriate Medical Forensic Techniques in the Criminal Justice System

Our AMA supports the availability and use of all appropriate medical forensic techniques in the criminal justice system.

H-80.995 Evaluation of the Use of DNA Identification Testing in Criminal Proceedings

(1) A national standard for uniform quality control guidelines should be developed which would govern: (a) appropriate control procedures to minimize the adverse effects of contamination and degradation; (c) an objective standard for identifying separate DNA bands and declaring a match between two or more DNA samples; and (c) the creation and use of population databases which accurately reflect the ethnic composition of populations amongst which matches might be sought.

(2) The independent validation of each probe used for DNA identification testing should be conducted.

(3) Further research is needed to determine the effects of contamination and degradation on forensic samples.

(4) DNA testing of individuals for information in criminal cases should be conducted only where a warrant has been issued on the basis of a high degree of individualized suspicion. Maintaining the files of any individual who is no longer a suspect in a particular crime raises serious concerns regarding potential violations of privacy. Therefore it may not be appropriate to retain such files.

H-20.900 HIV, Sexual Assault, and Violence

Our AMA believes that HIV testing should be offered to all victims of sexual assault, that these victims should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained.

D-515.998 Resources for Victims of Domestic Abuse in the Adolescent Population

Our AMA will develop materials on domestic violence, partner abuse, date violence, and sexual violence (including but not limited to sexual assault, sexual harassment, stalking, and cyberstalking) that are suitable for use in junior high and high schools and work with the Alliance and state medical societies in an effort to ensure the distribution and placement of these materials in junior high and high schools around the country.

H-75.985 Access to Emergency Contraception

It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the

emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.

H-515.956 Addressing Sexual Assault on College Campuses

Our AMA 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.

D-430.999 Preventing Assault And Rape Of Inmates By Custodial Staff

Our AMA urges: (1) that all states have legislation that protects prisoners from sexual misconduct and assault; and (2) physicians who work within prisons to ensure procedures are followed for preventing sexual misconduct and assault of prisoners by staff and appropriately managing prisoners if abuse or assault does occur; the investigation of sexual misconduct should be confidential with information disclosed only to those individuals involved in the process.

H-515.967 Protection of the Privacy of Sexual Assault Victims

The AMA opposes the publication or broadcast of sexual assault victims' names, addresses, or likenesses without the explicit permission of the victim.

H-515.968 Informing the Public & Physicians about Health Risks of Sedative Hypnotics, Especially Rohypnol

The AMA re-emphasizes to physicians and public health officials the fact that Rohypnol (a benzodiazepine), other benzodiazepines, and other sedatives and hypnotics carry the risk of misuse, morbidity and mortality. The AMA supports public education and public health initiatives regarding the dangers of the use of sedatives and hypnotics in sexual abuse and rape, especially when mixed with ethanol ingestion.

D-350.985 Addressing Sexual Violence and Improving American Indian and Alaska Native Women's Health Outcomes

1. Our AMA advocates for mitigation of the critical issues of American Indian/Alaska Native women's health that place Native women at increased risk for sexual violence, and encourages allocation of sufficient resources to the clinics serving this population to facilitate health care delivery commensurate with the current epidemic of violence against Native women.
2. Our AMA will collaborate with the Indian Health Service, Centers for Disease Control and Prevention (CDC), Tribal authorities, community organizations, and other interested stakeholders to develop programs to educate physicians and other health care professionals about the legal and cultural contexts of their American Indian and Alaska Native female patients as well as the current epidemic of violence against Native women and the pursuant medical needs of this population.
3. Our AMA will collaborate with the Indian Health Service, CDC, Tribal authorities, and community organizations to obtain or develop appropriate American Indian and Alaska Native women's health materials for distribution to patients in the spirit of self-determination to improve responses to sexual violence and overall health outcomes.

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

Our AMA:(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; (b)(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; (c) (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; (d) (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; (e) (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (f) (g) are part of an overall health education program; (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, consent communication to prevent dating violence and reduce substance use 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; and (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on health relationships, sexual health, conversations about consent and substance abuse. (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) (MSS Res 24, I-15) (AMA Res 405, A-16 Adopted as Amended with Change in Title to "Sexual Violence Education and Prevention in Schools" [])

D-515.982 Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse

Our AMA will work with members of the Federation of Medicine and other appropriate organizations to educate physicians on (1) the relationship between domestic violence and child abuse and (2) the appropriate role of the physician in treating patients when domestic violence and/or child abuse are suspected.

H-515.989 Evidence of Standards for Child Sexual Abuse

The AMA continues to support the standardization of evidence in child sexual abuse cases and urges that examination and treatment of child abuse victims be done by a physician.

D-515.984 Health Care Costs of Violence and Abuse Across the Lifespan

1. Our AMA urges Congress to commission the Institute of Medicine to study and issue a report on the impact and health care costs of violence and abuse across the lifespan.

2. Our AMA: (a) encourages the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Centers for Disease Control and Prevention to conduct research on the cost savings resulting from health interventions on violence and abuse; and (b) will develop and implement a strategy to advocate for increased funding for such research.
3. Our AMA encourages the appropriate federal agencies to increase funding for research on the impact and health care costs of elder mistreatment.

H-65.974 Gender-Based Violence

Our AMA: (1) opposes inhumane treatment of people of both genders; and (2) encourages the development of programs to educate and alert all cultures to remaining practices of inhumane treatment based on gender and promote recognition of abusive practices and adequate health care for victims thereof.

H-515.962 Renewed Focus on Domestic Violence

Our AMA will renew its commitment to combat family and intimate partner violence by including violence prevention and education as part of the ongoing strategic planning process.

H-185.976 Insurance Discrimination Against Victims of Domestic Violence

Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence.

H-295.912 Education of Medical Students and Residents about Domestic Violence Screening

The AMA will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient.

H-515.965 Family and Intimate Partner Violence

(1) Our AMA believes that all forms of family and intimate partner violence are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of victims. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society. Our AMA's efforts will be guided, in part, by its Advisory Council on Family Violence.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula when developed. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist victims. Our

AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter victims on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to:

- (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care;
- (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course;
- (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible;
- (d) Have written lists of resources available for victims of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid;
- (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence;
- (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from victimization;
- (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either victims or abusers themselves;
- (h) Give due validation to the experience of victimization and of observed symptomatology as possible sequelae;
- (i) Record a patient's victimization history, observed traumata potentially linked to the victimization, and referrals made;
- (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level;

(4) Within the larger community, our AMA: (a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all victims of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

(b) Believes it is critically important that programs be available for victims and perpetrators of intimate violence.

(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA opposes the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult victims of intimate partner violence if the required reports identify victims. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of victims' identities; (b) allow competent adult victims to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and

(e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that: (a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.

(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.

(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.

(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.

(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.

H-515.975 Alcohol, Drugs, and Family Violence

(1) Given the association between alcohol and family violence, physicians should be alert to look for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse, should screen for alcohol use. (2)

Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence. (3) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.

515.005MSS Protection of the Privacy of Sexual Assault Victims:

AMA-MSS will ask the AMA to condemn the publication or broadcast of sexual assault victims' names, addresses, or likenesses without the explicit permission of the victim. (MSS Sub Res 21, I-97) (AMA Res 406, A-98 Adopted [H-515.967]) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)

515.009MSS Addressing Sexual Assault on College Campuses:

AMA-MSS will ask our AMA support 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. (MSS Res 7, I-15) (AMA Res 402, A-16 Adopted [])

295.067MSS Medical Education about Rape Crises:

AMA-MSS will ask the AMA to encourage medical schools to incorporate information about rape exam procedures, the rape trauma syndrome, the psychological needs of rape victims, and available rape support groups into their clinical preparation curriculum. (AMA Amended Res 301, I-95 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

515.001MSS Identifying Victims of Adult Domestic Violence:

AMA-MSS will ask the AMA to: (1) work with social services and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of adult domestic violence and to better serve all of the victim's needs including medical, legal and social aspects; and (2) ask the appropriate organizations to support the inclusion of curricula that address adult domestic violence (AMA Res 419, I-91 Adopted [D-515.985]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

295.078MSS Teaching Domestic Violence Screening:

AMA-MSS will ask the AMA to encourage editors and publishers of medical training literature to include (1) domestic violence screening questions in recommendations and guidelines for conducting a comprehensive medical history and (2) domestic violence intervention and documentation protocols. (Reaffirmed Existing Policy in Lieu of AMA Res 402, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

295.079MSS Education of Medical Students About Domestic Violence Histories:

AMA-MSS will ask the AMA to continue its support for the education of medical students on domestic violence by advocating that medical schools and post-graduate medical programs immediately begin training students and resident physicians to sensitively inquire about family abuse with all patients regardless of chief complaint or risk. (AMA Amended Res 303, I-96 Adopted [H- 295.912]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

515.007MSS Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse:

AMA-MSS will ask the AMA to work with members of the Federation of Medicine and other appropriate organizations to educate physicians on (1) the relationship between domestic violence and child abuse and (2) the appropriate role of the physician in treating patients when domestic violence and/or child abuse are suspected. (MSS Sub Res 1, I-08) (AMA Res 415, A-09 Adopted [D-515.982]) (Reaffirmed: MSS GC Rep A, I-14)

170.010MSS Abstinence-Only Education and Federally-Funded Community-Based Initiatives:

AMA-MSS supports initiatives to: (1) extend AMA 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 H-170.968; (2) oppose federal funding of community-based abstinence-only sex education programs and instead support federal funding of comprehensive sex education programs that teach about contraceptive choices and safe sex while also stressing the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections; and (3) support school education programs that include recognizing and preventing sexual abuse and dating violence. (MSS Res 23, I-04) (AMA Amended Res 834 Adopted [H- 170.968]) (Amended: MSS Late Res 1, A-12)

170.016MSS Sexual Violence Education and Prevention in High Schools with Sexual Health Curricula:

AMA- MSS will ask that our AMA amend policy H-170.968 by insertion and deletion as follows:

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools. Our AMA (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; (b)(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; (c) (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; (d) (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; (e) (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (f) (g) are part of an overall health education program; (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, consent communication to prevent dating violence and reduce substance use 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; and (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on health relationships, sexual health, conversations about consent and substance abuse. (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)

(MSS Res 24, I-15) (AMA Res 405, A-16 Adopted as Amended with Change in Title to "Sexual Violence Education and Prevention in Schools" [])

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 22
(A-17)

Introduced by: Region 1; Region 3; Franklyn Rocha-Cabrero University of Illinois College of
Medicine-Rockford

Subject: Improving Medical Care in Immigrant Detention Centers

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, The United States has the largest immigration detention structure in the world with
2 over 600 facilities detaining between 380,000 to 442,000 persons per year;¹ and
3
4 Whereas, Apprehension of undocumented immigrants along the Southwest border of the U.S.
5 increased by 16% from September 2016 to October 2016;² and
6
7 Whereas, The U.S. Immigration and Customs Enforcement (ICE) is a federal agency that also
8 contracts with private detention centers where more than half of detainees are held;³ ICE
9 detention rose to 41,000 while maintaining between 31,000 to 34,000 beds;² and
10
11 Whereas, The current administration has urged the Department of Homeland Security to
12 increase ICE activity and accelerate the detention and deportation of undocumented
13 immigrants;^{4,16} and
14
15 Whereas, Those living “unlawfully” in the United States and pose a threat to public safety are
16 either removed or placed in mandatory detention, while “low-risk” undocumented immigrants are
17 placed in various forms of intense supervision versus in detention;² and
18
19 Whereas, As of January 2015, 140 ICE facilities that hold nearly half of detained immigrants
20 operate under health care standards from as early as 2000, prior to the creation of ICE;⁵ and
21
22 Whereas, A total of 167 deaths have occurred in ICE detention facilities from 2003 to present,^{6,15}
23 and six of eight deaths due to substandard medical care between 2010 and 2012 occurred in
24 for-profit immigrant detention facilities;⁷ and
25
26 Whereas, For-profit companies prioritize maintaining low-cost detention centers, therefore
27 health care, mental health care, and food have been negated to maximize profits;⁸ and
28
29 Whereas, Despite the devastating health conditions in private detention facilities, ICE continues
30 to utilize these facilities to control costs and handle increased numbers in detention;^{8,9} and
31
32 Whereas, ICE detention facilities have a history of basic human rights abuses; substandard
33 living conditions; and inconsistent access to quality medical, dental, and mental care, often in
34 violation of their own 2011 Performance-Based National Detention Standards (PBNDS);^{7,10-14} and
35
36 Whereas, ICE’s own PBNDS note that their medical facilities within detention centers should
37 comply with those of the National Commission on Correctional Health Care (NCCHC);¹¹ and

1
2 Whereas, The ICE Office of Detention Oversight and the Enforcement and Removal Operations
3 have provided data, demonstrating that substandard medical care in immigrant detention
4 facilities has led to preventable deaths, yet deficient ICE inspections in spite of the PBNDS
5 allows for these issues to continue or worsen;^{7,10} and
6

7 Whereas, ICE never created a system to track the quality of healthcare provided in its facilities
8 or to track complaints filed by detainees;^{5,6} and
9

10 Whereas, The White House has issued immigration executive orders to expand authority for
11 immigration officers, dramatically increase efforts to detain and deport undocumented
12 immigrants, and increase the number of immigrant detainees in ICE facilities;¹³ and
13

14 Whereas, Current AMA policies **H-430.997**, **D-430.997**, and **H-430.986** support and advocate
15 for humane and highest standards of care of detained and incarcerated individuals but does not
16 explicitly address the unique healthcare standards and needs of undocumented immigrants
17 under the custody of the U.S. Immigration and Custom Enforcement, compliant with the
18 National Commission on Correctional Health Care Standards; therefore be it
19

20 RESOLVED, That our AMA issue a public statement urging U.S. Immigrations and Customs
21 Enforcement Office of Detention Oversight to 1) revise its medical standards governing
22 the conditions of confinement at detention facilities to meet or exceed those set by the National
23 Commission on Correctional Health Care, 2) take necessary steps to achieve full compliance
24 with these standards, and 3) create a system to track complaints related to substandard
25 healthcare quality filed by detainees; and be it futher
26

27 RESOLVED, That our AMA encourages the U.S. Immigration and Customs Enforcement to
28 desist, terminate, and do not renew private contracting with companies that do not guarantee or
29 meet the highest quality of medical, mental, and dental care of undocumented immigrants as
30 guided by the National Commission on Correctional Health Care; and be it further
31

32 RESOLVED, That this matter be immediately forwarded to the AMA House of Delegates.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Standards of Care for Inmates of Correctional Facilities H-430.997

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism. Res. 60, A-84 Reaffirmed by CLRPD Rep. 3 - I-94 Amended: Res. 416, I-99 Reaffirmed: CEJA Rep. 8, A-09 Reaffirmation I-09 Modified in lieu of Res. 502, A-12 Reaffirmation: I-12

Health Status of Detained and Incarcerated Youth H-60.986

Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;

(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.

(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.

(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system CSA Rep. C, A-89 Reaffirmed: Sunset Report, A-00 Appended: Res. 401, A-01 Reaffirmed: CSAPH Rep. 1, A-11 Reaffirmed: CSAPH Rep. 08, A-16 Reaffirmed: Res. 917, I-16

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:

(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;

(2) encourage all correctional systems to support NCCHC accreditation;

(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding; and

(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities. Res. 440, A-04 Amended: BOT Action in response to referred for decision Res. 602, A-00 Reaffirmation I-09 Reaffirmation A-11 Reaffirmed: CSAPH Rep. 08, A-16 Reaffirmed: CMS Rep, 02, I-16

Disease Prevention and Health Promotion in Correctional Institutions H-430.989

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing. CSA Rep. 4, A-03 Modified: CSAPH Rep. 1, A-13

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women. CMS Rep. 02, I-16

Shackling of Pregnant Women in Labor H-420.957

1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:
 - An immediate and serious threat of harm to herself, staff or others; or
 - A substantial flight risk and cannot be reasonably contained by other means.If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."
2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist. Res. 203, A-10

Improving the Intersection Between Law Enforcement and the Mentally Ill 345.008MSS

AMA-MSS recognizes Crisis Intervention Team (CIT) training as an effective tool for 1) educating law enforcement officers about the mentally ill, 2) diverting mentally ill offenders from jails and prisons to medical treatment centers, and 3) developing a more judicious use-of-force by law enforcement in encounters with patients in mental health crises; and supports the National Mental Health Alliance and other national and local mental health organizations to advocate for the development and nationwide implementation of training programs, such as

CIT, that are designed to improve law enforcement's responses to the mentally ill. (MSS Res 5, A-15)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 23
(A-17)

Introduced by: Kate Topalis, Gregory de Gruchy, Devin Bageac, Shaan Kamal, Prakhar Bansal; University of Connecticut School of Medicine
Anish Parekh and Ali Tafreshi; Keck School of Medicine at USC
Farouk Abu Alhana; University of Toledo School of Medicine

Subject: Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1
2 Whereas, Anthropogenic climate change is now widely recognized as the “extremely likely”
3 contributing source of the post-industrial rise in global temperatures, resulting in a shift by one
4 standard deviation in summer hemisphere mean temperature anomalies and a subsequent rise
5 in unpredictable weather patterns, natural disasters, and extreme temperatures worldwide;^{1,2}
6 and
7
8 Whereas, These climate shifts are directly linked to a rise in a multitude of negative public
9 health impacts, including surges in the prevalence and frequency of asthma exacerbations,
10 vector-borne illnesses, natural disasters, and extreme temperature-related deaths;³⁻⁵ and
11
12 Whereas, The primary goal of the American Medical Association is to “promote the art and
13 science of medicine and the betterment of public health;” and
14
15 Whereas, Renewable energy diminishes greenhouse gas emission, water use, and sources of
16 air pollution from sulfur dioxide, nitrogen oxides, and particulate matter when compared to
17 nonrenewable sources,⁶ all factors which play a role in the subsequent negative health impacts
18 of climate change; and
19
20 Whereas, Natural gas, through its associated extraction methods, subsequent runoff, and
21 unintentional leaks, is currently a well-documented source of methane, benzene, propane,
22 ethanol, carbon dioxide, and other contaminants, all of which can pollute the surrounding water
23 table and atmosphere and endanger the health of proximal and distant populations;^{4,6-8} and
24
25 Whereas, Nonrenewable extraction methods require the use of significant amounts of water,^{6,8}
26 coupled with the fact that many shale formations are located in arid regions already struggling
27 with insufficient water supply;⁹ and
28
29 Whereas, Vulnerable populations, including those often impacted negatively by social
30 determinants of health, are disproportionately affected by the negative health effects of climate
31 change;^{10,11} and
32

1 Whereas, the 2005 Energy Policy Act “exempted gas industries from any federal regulation and
2 oversight under the Safe Drinking Water Act,” thereby allowing natural gas companies to bypass
3 safety standards originally put in place to safeguard surrounding communities from potential
4 contamination and runoff;¹² and

5
6 Whereas, Existing AMA policy directly addresses the potential issues involved with hydraulic
7 fracturing, especially emphasizing the need for “full disclosure of chemicals placed into the
8 natural environment during the petroleum, oil and natural gas exploration and extraction
9 process” (H-135.931), and yet continues to promote natural gas as a viable source of energy
10 (H-135.949), even without such required regulatory procedures in place; and

11
12 Whereas, Our AMA has supported community regulation of “all forms of air pollution including
13 particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically
14 active pollutants... particularly if these are accompanied by a significant incidence of chronic
15 respiratory diseases in the affected community” (H-135.998); and

16
17 Whereas, Studies have demonstrated that conventional and unconventional methods of oil
18 extraction, including acidization, vertical and horizontal drilling, and drilling in urban areas
19 releases volatile organic compounds and heavy metals into local communities, including but not
20 limited to methanol, ozone, crystalline silica, methanol, hydrochloric acid, formaldehyde,
21 hydrofluoric acid, naphthalene, xylene, and ethylbenzene;^{13,14} and

22
23 Whereas, Naphthalene, methanol, formaldehyde, hydrochloric acid and hydrofluoric acid are
24 associated with damage to multiple organ systems, including but not limited to the skin, eyes,
25 and lungs, ozone increases smog production and the incidence of asthma, and chronic
26 exposure to crystalline silica causes lung and autoimmune diseases;¹⁵⁻²³ and

27
28 Whereas, Urban oil wells, drilling and refining facilities are often located close to residences,
29 schools, hospitals, and religious institutions, especially in low income communities and
30 communities of color;²⁴⁻³⁰ and

31
32 Whereas, Proximity to oil and gas development activities has been associated with reproductive
33 abnormalities including congenital heart abnormalities, premature birth, high risk pregnancies,
34 and low birth weight;³¹⁻³⁴ and

35
36 Whereas, Individuals within one kilometer (3,280 feet) of well stimulation or other urban oil and
37 gas development activities demonstrate higher rates of self-reported skin and respiratory
38 symptoms including asthma, headache, nausea, epistaxis, experience greater ambient noise
39 levels, and have a higher incidence of leukemia and a higher hazard index for chronic
40 disease;³⁵⁻⁴⁰ and

41
42 Whereas, Numerous states, cities, and towns have enacted buffer zones or setbacks ranging
43 from 150 to 1,500 feet (45 to 407 meters) between well stimulation and sensitive public land
44 uses, commissioned research into buffer zone distances, or banned drilling activities
45 completely;⁴¹⁻⁴⁵ and

46
47 Whereas, Buffer zones less than 1,000 feet may not be sufficient to protect public health in
48 areas with active well stimulation;⁴⁶ and

49
50 Whereas, In order to truly prioritize public health as the fundamental goal of AMA policy,
51 renewable energy sources must be recognized as the primary choice for current and future

1 energy shifts, and promoted as such not only through research, but also through a systematic
2 overhaul of current energy infrastructure and widespread implementation of renewable energy
3 sources; therefore be it,
4

5 RESOLVED, That our AMA amend policy H-135.949 by insertion and deletion as follows:
6

7 Support of Clean Air and Reduction in Power Plant Emissions H-135.949
8

9 Our AMA supports (1) federal legislation and regulations that meaningfully reduce the
10 following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and
11 nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of
12 the burning of coal in the nation's power generating plants, efforts to improve the
13 efficiency of power plants, ~~substitution of natural gas in lieu of other carbon-based fossil~~
14 ~~fuels~~, continued development of alternative renewable energy sources and an energy
15 infrastructure that fosters this growth, and efforts to prioritize and facilitate the
16 widespread substitution and utilization of renewable energy; and be it further
17

18 RESOLVED, That our AMA opposes all oil and gas development in close proximity to
19 residences, schools, hospitals, and religious institutions and advocates for significant health and
20 safety buffer zones to create a setback between these land uses and all oil wells.

Fiscal note: TBD

Date received: 04/20/2017

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Relevant AMA and AMA-MSS Policy:

Global Climate Change: The "Greenhouse Effect" (H-135.977)

Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;

(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;

(3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity;

(4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and

(5) encourages humanitarian measures to limit the burgeoning increase in world population.

AMA Advocacy for Environmental Sustainability and Climate (H-135.923)

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.

Green Initiatives and the Health Care Community (H-135.939)

Our AMA supports: (1) responsible waste management policies, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

The Health Risks of Hydraulic Fracturing (H-135.931)

1. Our AMA encourages appropriate agencies and organizations to study the potential human and environmental health risks and impacts of hydraulic fracturing.

2. Our AMA: (A) supports the full disclosure of chemicals placed into the natural environment during the petroleum, oil and natural gas exploration and extraction process; and (B) supports the requirement that government agencies record and monitor the chemicals placed into the natural environment for petroleum oil and natural gas extraction and the chemicals found in flowback fluids, to monitor for human exposures in well water and surface water, and to share this information with physicians and the public.

Radioactive/Chemical Waste and Radiation in the Environment (D-135.991)

Our AMA will:

- (1) advocate for the development of a transparent, comprehensive national policy and plan for the disposition of US Department of Energy (DOE) radioactive and chemical waste;
- (2) support independent, comprehensive environmental testing at all nuclear facilities throughout the country and that the results of any testing be made available to the public;
- (3) urge the appropriate federal and state agencies to monitor and/or evaluate the health status of residents in the area of leaking nuclear facilities to accurately determine any adverse impact on health status by leakage of radioactive materials, and make public these results; and
- (4) support measures that strengthen the coordination and oversight of nuclear facilities.

Coal-Tar Based Sealcoat Threat to Human Health and the Environment (D-135.970)

Our AMA will advocate for legislation to ban the use of pavement sealcoats that contain polycyclic aromatic hydrocarbons (PAH) or require use of sealcoat products that contain minimal PAH.

Environmental Health Programs (H-135.969)

Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.

Stewardship of the Environment (H-135.973)

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation. (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Modern Chemicals Policies (H-135.942)

Our AMA supports: (1) the restructuring of the Toxic Substances Control Act to serve as a vehicle to help federal and state agencies to assess efficiently the human and environmental health hazards of industrial chemicals and reduce the use of those of greatest concern; and (2) the Strategic Approach to International Chemicals (SAICM) process leading to the sound management of chemicals throughout their life-cycle so that, by 2020, chemicals are used and produced in ways that minimize adverse effects on human health and the environment.

Clean Air (H-135.991)

- (1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.
- (2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.
- (3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants.
- (4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.
- (5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health.

Reducing Sources of Diesel Exhaust (D-135.996)

Our AMA will:

- (1) encourage the US Environmental Protection Agency to finalize the most stringent feasible standards to control pollutant emissions from both large and small non-road engines including construction equipment, farm equipment, boats and trains;
- (2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from existing diesel; and
- (3) call for all trucks traveling within the United States, regardless of country of origin, to be in compliance with new diesel emissions standards promulgated by US EPA.

The Need for Increased Research and Development in Nuclear Fusion to Reduce Environmental Pollution (H-460.956)

Our AMA urges Congress, the Administration, energy companies, and organized public interest groups to press for the establishment of a national strategy for energy research and production that includes appropriate consideration, support and development of fusion technology. The strategy should include a prolonged commitment and the appropriate funding to accomplish this mission in the most reasonable period of time.

Air Pollution and Public Health (H-135.941)

Our AMA supports increased physician participation in regional and state decision-making regarding air pollution across the United States.

Air Pollution and Public Health (D-135.985)

Our AMA: (1) promotes education among its members and the general public and will support efforts that lead to significant reduction in fuel emissions in all states; and (2) will declare the

need for authorities in all states to expeditiously adopt, and implement effective air pollution control strategies to reduce emissions, and this position will be disseminated to state and specialty societies.

Expense of Biohazardous Waste Removal (H-135.985)

(1)The AMA encourages the Environmental Protection Agency (EPA): (a) to explore the feasibility of establishing a national definition of biohazardous waste, emphasizing the origins and relative importance of wastes that can plausibly transmit infection compared with wastes that cannot, and (b) to monitor the sources of medical waste in environmental settings and develop guidelines applicable to all waste generators, including home health care sites, to reduce these sources of environmental pollution. (2)The AMA will work with appropriate governmental agencies and medical societies to educate physicians about the management of biohazardous waste and advocate that these groups work collectively to attain cost savings in biohazardous waste management.(3) The AMA urges practicing physicians to develop a biohazardous waste management program that fulfills their county, state, and municipal regulations, and that considers the different health risks to employees and the general public.

Pollution Control and Environmental Health (H-135.996)

Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.

AMA Position on Air Pollution (H-135.998)

Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.

(2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.

(3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.

(4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.

Clean Air (H-135.979)

Our AMA supports cooperative efforts with the Administration, Congress, national, state and local medical societies, and other organizations to achieve a comprehensive national policy and program to address the adverse health effects from environmental pollution factors, including air and water pollution, toxic substances, the "greenhouse effect," stratospheric ozone depletion and other contaminants.

Risks of Nuclear Energy and Low-Level Ionizing Radiation (H-455.994)

Our AMA supports the following policy on nuclear energy and low-level ionizing radiation: (1) Usefulness of Nuclear Energy: Energy produced by nuclear reactors makes an important contribution to the generation of electricity in the US at present, and it will continue to do so in the foreseeable future. Investigation and research should continue in order to develop improved safety and efficiency of nuclear reactors, and to explore the potential of competing methods for

generating electricity. The research should include attention to occupational and public health hazards as well as to the environmental problems of waste disposal and atmospheric pollution.

(2) Research on Health Effects of Low Level Radiation: There should be a continuing emphasis on research that is capable of determining more precisely the health effects of low level ionizing radiation.

(3) Uranium Mill Tailings: Uranium mill tailings should be buried or otherwise covered.

(4) Radioactive Waste Disposal: There should be acceleration of pilot projects to evaluate techniques for the disposal of high-level radioactive wastes. The decommissioning of nuclear reactors is a source of nuclear waste which requires accelerated technological investigation and planning. Local laws should be modified to allow the disposal of low level radioactive waste materials in accordance with AMA model state legislation.

(5) Occupational Safety: The philosophy of maintaining exposures of workers at levels "as low as reasonably achievable (ALARA)" is commended. The present federal standards for occupational exposure to ionizing radiation are adequate. The responsibilities of the various federal agencies regarding workers in the nuclear energy industry should be clarified; these agencies include the Departments of Energy, Defense, HHS, Labor and Transportation; and the NRC, VA and EPA.

(6) Minimizing Exposures to Radiation: Each physician should attempt to minimize exposures of patients to ionizing radiation in accord with good medical practice.

(7) Radiation Exposure Standards: The present standards for exposure of populations to ionizing radiation are adequate for the protection of the public.

(8) Emergencies and Governmental Readiness: Government agencies at all levels should be prepared to respond to nuclear energy-related emergencies. There is need for improved public planning by the several federal agencies involved, including the Federal Emergency Management Agency (FEMA) and the agencies of state and local governments. Responsible officials should develop skills and undergo periodic retraining in order to be able to act appropriately during major radiation emergencies. Because emergency planning is a complex task involving aspects of health as well as problems related to utilities, state and local governments and the federal government (FEMA) would benefit from the cooperation of physicians and others in the health sciences.

(9) Federal Radiation Emergency Planning Responsibilities: Federal groups such as the NRC and FEMA must work together closely to fulfill responsibilities in radiological emergency preparedness and in crisis management. There is a need for NRC and FEMA to define better the roles of community hospitals and of physicians.

(10) Reactor Operators and Radiation Inspectors: There is a need for better training of operating personnel with regard to prevention and management of untoward reactor operating conditions. Selection, training, and ongoing performance evaluation of operating personnel, and of radiation inspectors, are key elements in the safety of reactor workers and of the public. Physicians should help develop methods of selecting and evaluating personnel in the nuclear power industry.

(11) Radiation Training for Physicians: Physicians should be prepared to answer the questions of their patients about ionizing radiation, especially if there is a radiation emergency. Each hospital should have adequately trained physicians and a plan and protocol for receiving and caring for radiation victims.

(12) Radiation Education for the Public: Further education of the public about ionizing radiation is recommended.

(13) Location of Nuclear Reactors: All nuclear reactors built in the future should be placed in areas of low population density; present reactors located in low density areas should be managed so that the populations surrounding them remain small.

(14) Multiple Sources of Power Generation: AMA recommends the use of a diverse set of electricity generating methods and a continuing emphasis on the conservation of energy.

(15) X-Ray Security Scanners: Our AMA: (1) believes that as of June 2013, no data exist to suggest that individuals, including those who are especially sensitive to ionizing radiation, should avoid backscatter security scanners due to associated health risks; and (2) supports the adoption of routine inspection, maintenance, calibration, survey, and officer training procedures meant to ensure that backscatter security scanners operate as intended.

Childhood Anaphylactic Reactions (D-60.976)

Our AMA will: (1) urge all schools, from preschool through 12th grade, to: (a) develop Medical Emergency Response Plans (MERP); (b) practice these plans in order to identify potential barriers and strategies for improvement; (c) ensure that school campuses have a direct communication link with an emergency medical system (EMS); (d) identify students at risk for life-threatening emergencies and ensure these children have an individual emergency care plan that is formulated with input by a physician; (e) designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families; (f) train school personnel in cardiopulmonary resuscitation; (g) adopt the School Guidelines for Managing Students with Food Allergies distributed by FARE (Food Allergy Research & Education); and (h) ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff are familiar with using this equipment; (2) work to expand to all states laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis; (3) support increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis; (4) urge the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies; (5) urge physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan; and (6) work to allow all first responders to carry and administer epinephrine in suspected cases of anaphylaxis.

Asthma Control (H-160.932)

The AMA: (1) encourages physicians to make appropriate use of evidence-based guidelines, including those contained in Expert Panel Report III: Guidelines for the Diagnosis and Management of Asthma released by the National Heart, Lung and Blood Institute; (2) encourages physicians to provide self-management education tailored to the literacy level of the patient by teaching and reinforcing appropriate self-monitoring, the use of a written asthma action plan, taking medication correctly, and avoiding environmental factors that worsen asthma; and (3) encourages physicians to incorporate the four components of care (assessment and monitoring; education; control of environmental factors and comorbid conditions; and appropriate medication selection and use).

Protective NAAQS Standard for Fine Particulate Matter ((PM-2.5) (H-135.946))

Our AMA supports more stringent air quality standards for particulate matter than those proposed by the EPA Administrator. This position is supported by several medical specialty societies.

Support the Health-Based Provisions of the Clean Air Act (H-135.950)

Our AMA (1) opposes changes to the New Source Review program of the Clean Air Act; (2) urges the Administration, through the Environmental Protection Agency, to withdraw the proposed New Source Review regulations promulgated on December 31, 2002; and (3) opposes further legislation to weaken the existing provisions of the Clean Air Act.

Protective NAAQS Standard for Fine Particulate Matter ((PM-2.5) (D-135.983))

Our American Medical Association will: (1) submit comments during the public comment period on the National Ambient Air Quality Standards (NAAQS) supporting a tightening of the NAAQS for fine particulate matter (PM 2.5); and (2) specifically request a NAAQS that provides improved protection for our patients which includes: 12 $\mu\text{g}/\text{m}^3$ for the average annual standard; 25 $\mu\text{g}/\text{m}^3$ for the 24-hour standard; 99th percentile used for compliance determination

Protective NAAQS Standard for Particulate Matter ((PM 2.5 and PM 10) (D-135.978))

At such time as a new EPA Proposed Rule on National Ambient Air Quality Standards for Particulate Matter is published, our AMA will review the proposal and be prepared to offer its support for comments developed by the American Thoracic Society and its sister organizations.

Support of Clean Air and Reduction in Power Plant Emissions (H-135.949)

Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants, substitution of natural gas in lieu of other carbon-based fossil fuels, and continued development of alternative renewable energy sources.

Federal Clean Air Legislation (H-135.984)

The AMA urges the enactment of comprehensive clear ambient air legislation which will lessen risks to human health.

135.002MSS Environmental Protection:

AMA-MSS will ask the AMA to support strong federal enforcement of environmental protection regulations. (AMA Res 80, A-82 Referred) (BOT Rep D, I-82 Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

135.005MSS Promotion of Conservation Practices within the AMA:

AMA-MSS will ask the AMA to direct its offices to implement conservation-minded practices whenever feasible. (AMA Res 16, A-91 Adopted [G-630.100]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

135.012MSS Toward Environmental Responsibility:

AMA-MSS will ask the AMA to recognize the negative impact of climate change on global human health, particularly in the areas of infectious disease, the direct effects of heat, severe storms, food and water availability, and biodiversity. (MSS Amended Rep A, I-07) (AMA Res 607, A-08 Referred) (Modified: MSS GC Report A, I-16)

135.013 MSS Statement of Sustainability Principles:

AMA-MSS will (1) develop a model sustainability statement that medical schools can use as a template for creating institution-specific sustainability mission statements; and (2) encourage all medical schools to adopt mission statements which promote institutional sustainability initiatives such as consumption awareness, waste reduction, energy and water conservation, and the utilization of reusable/recyclable goods. (MSS Res 2, A-10) (Reaffirmed: MSS Res 10, I-11) (Reaffirmed, MSS GC Rep D, I-15)

440.055 MSS Oil and Gas Well-Stimulation Disclosure and Moratorium:

AMA-MSS supports legislation and regulations that require the full disclosure of chemicals placed into the natural environment for petroleum, oil, and gas exploration and extraction. (MSS Res 48, A-15)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 24
(A-17)

Introduced by: Eric Walton, Kaitlyn Dobesh, Brenton Kinker, Wayne State University School of Medicine

Subject: Opposing Physician Participation in Court-Initiated Castration

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Seven states - including California, Florida, Iowa, Louisiana, Montana, Texas, and
2 Wisconsin - currently allow persons convicted of certain sexual crimes to be sentenced to
3 forcible chemical or voluntary surgical castration;^{1,2,3,4,5,6,7} and
4

5 Whereas, The AMA Code of Medical Ethics Opinion 9.7.2 states that, for a physician to
6 participate in court-initiated treatment involving in-patient therapy, surgical intervention, or
7 pharmacological treatment, the “diagnosis must be confirmed by an independent physician or a
8 panel of physicians not responsible to the state”; and
9

10 Whereas, The AMA Code of Medical Ethics Opinion 9.7.2 also states, “[The physician] must be
11 able to conclude, in good conscience and to the best of his or her professional judgment, that to
12 the extent possible the informed consent was given voluntarily, recognizing the element of
13 coercion that is inevitably present”; and
14

15 Whereas, Historically, the “right to conscience” has been an acceptable reason for physicians to
16 abstain from participating in medical procedures;⁸ and
17

18 Whereas, The AMA Code of Medical Ethics Opinion 9.7.2 additionally requires confirmation by
19 an independent physician or panel of physicians that the informed consent was given within the
20 parameters stated above; and
21

22 Whereas, Compliance with the informed consent provision is difficult in states where chemical
23 castration is either left to the discretion of the judge at sentencing or mandated by
24 statute;^{1,2,3,4,5,6,7} and
25

26 Whereas, Only 78.1 percent of chemical castration patients gave written consent and only 71.9
27 percent were informed of possible risks of chemical castration;⁹ and
28

29 Whereas, The Preamble to the Code of Medical Ethics and the Principles of Medical Ethics,
30 Article 8 both state that the physician’s primary responsibility is the safety and care of the
31 patient; and
32

33 Whereas, The Food and Drug Administration (FDA) approves medroxyprogesterone acetate
34 (MPA), a progesterone derivative that inhibits the secretion of gonadotropins, as a contraceptive
35 in women under the trade name Depo-Provera CI;¹⁰ and
36

1 Whereas, MPA should be administered intramuscularly as a contraceptive in 150 mg doses
2 every 3 months for no longer than 2 years -- due to significant bone mineral density loss --
3 unless all other contraceptives are inadequate;¹⁰ and
4

5 Whereas, MPA chemical castration regimens aimed at reducing free testosterone levels utilize
6 weekly injections (typically 100-500 mg) for over two years;¹¹ and
7

8 Whereas, A recent meta-analysis of inmates convicted of sexual assault did not have higher
9 testosterone levels, as previously thought;¹² and
10

11 Whereas, In addition to significant reduction in bone density, metabolic changes after androgen
12 deprivation lead to weight gain and put patients at higher risk for diabetes, metabolic syndrome,
13 and atherosclerosis;¹³ and
14

15 Whereas, The majority of persons with pedophilic disorder experience another mental health
16 issue (e.g. anxiety) or antisocial personality disorder unrelated to sexual drive;¹⁴ and
17

18 Whereas, Non-pharmacological management with cognitive behavioral therapy is the standard
19 in states that do not utilize chemical castration;¹² and
20

21 Whereas, Recidivism rates (often poorly measured due to high study dropout rates) with
22 chemical castration range from 0 to 83 percent and are lowest when pharmacological treatment
23 is combined with cognitive-behavioral therapy;^{9,15} and
24

25 Whereas, Reduced recidivism depends on sustained androgen deprivation and removal of MPA
26 -- either due to non-adherence or treatment cessation -- leads to increased recidivism;¹¹ and
27

28 Whereas, A recent Cochrane review identified poor evidence to endorse chemical castration
29 and called for additional studies into the efficacy of these treatments;¹⁶ and
30

31 Whereas, The Principles of Medical Ethics, Article 3 of the Medical Code of Ethics states, "A
32 physician shall respect the law and also recognize a responsibility to seek changes in those
33 requirements which are contrary to the best interests of the patient"; and be it
34

35 RESOLVED, That our AMA oppose physician participation in court-initiated castration
36 treatments; and be it further
37

38 RESOLVED, That our AMA support the repeal of state laws allowing for persons convicted of a
39 crime to be required – as a condition of parole or probation – forcible chemical castration, or to
40 be sentenced to forcible chemical castration

References:

1. California Penal Code Sect. 645
2. Florida Sect. 794.0235
3. Iowa Code 903B.10
4. Louisiana Revised Statutes 15:538
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RELEVANT AMA AND AMA-MSS POLICY:

AMA Code of Medical Ethics, Opinion 9.7.2

Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.

In limited circumstances physicians can ethically participate in court-initiated medical treatments. Individual physicians who provide care under court order should:

- (a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
- (b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.

(c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.

(d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.

AMA Code of Medical Ethics, Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct that define the essentials of honorable behavior for the physician.

AMA Code of Medical Ethics, Principles of Medical Ethics

1. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
2. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
4. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
5. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
7. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
8. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
9. A physician shall support access to medical care for all people.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 25
(A-17)

Introduced by: John Lacci, Aliyah Ali, UTHealth San Antonio School of Medicine

Subject: Economic Sustainability and Improved Usage of Health Information Exchanges

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, The United States spends more on healthcare costs than almost any other developed
2 nation, expenditures that amounted to 17.8% of the nation's GDP, or \$9,990 per person in 2015,
3 which is at a 50% higher rate than the next most costly country, France (at 11.6%);^{1,2} and
4
5 Whereas, hospital care services (inpatient and outpatient) represented 32% of the health care
6 expenditures in 2015, a 5.6% increase from the previous year;² and
7
8 Whereas, medical imaging procedures are unnecessary about 20-40% of the time and
9 redundant when previous imaging results are unaccessible, which further contributes to higher
10 healthcare costs;^{3,4} and
11
12 Whereas, Health Information Exchanges (HIEs) are an electronic medium that allows healthcare
13 workers to securely share a patient's medically relevant information;⁵ and
14
15 Whereas, HIEs have been shown to improve adherence to evidence-based guidelines and
16 decrease the number of imaging studies ordered by efficiently sharing patient data between
17 providers and hospital systems and avoiding redundancy;^{6,7} and
18
19 Whereas, A pilot program in South Korea shows that effective HIEs can significantly decrease
20 the cost of overall health care, where the total healthcare costs in the HIE group were 13%
21 lower and diagnostic imaging costs 80% lower than a control group;⁸ and
22
23 Whereas, A study of 12 U.S. Emergency Departments utilizing HIEs in Memphis, Tennessee
24 showed a significant decrease in the odds of admission when web access to HIE information
25 was utilized, saving the health system \$1.07 million dollars after taking into account the

1 operating cost of the HIE;⁹ and

2

3 Whereas, There are economic and business disincentives in place that keep systems from
4 employing full interoperability, and sharing data with competing health systems;¹⁰ and

5

6 Whereas, The AMA already supports initiatives that will increase the ease of transferability of
7 patients' health records between different health systems and also facilitate health information
8 technology interoperability between practices and hospital providers (D-478.996, H-406.987);
9 therefore be it

10

11 RESOLVED, That our AMA support further funding to train and educate physicians and other
12 health-care professionals of the proper usage and known benefits of Health Information
13 Exchanges (HIEs); and be it further

14

15 RESOLVED, That our AMA support legislation that provides steady, long-term government
16 funding towards sustainability of the infrastructure inherent in Health Information Exchanges
17 (HIEs).

Fiscal Note: TBD

Date Received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Information Technology Standards and Costs D-478.996

Our AMA will:

- (1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems;
- (2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices;
- (3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems;
- (4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and

(5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

Medical Information and Its Uses H-406.987

DATA TRANSPARENCY PRINCIPLES TO PROMOTE IMPROVEMENTS IN QUALITY AND CARE DELIVERY

Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals

Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources

Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.

Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.

Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.

Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.

Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Challenges to Transparency

Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.

Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.

Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers.

Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians D-478.976

1. Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-

source status; and (C) through its partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and support more informed decision making in the selection of EHRs.

2. Our AMA will, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and formulate more formal decision making in the selection of EHRs.

3. Our AMA will work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes.

4. Our AMA will study medical scribe utilization in various health care settings.

5. Our AMA will make available the findings of the AmericanEHR Partners' survey and report back to the House of Delegates.

Health Information Technology D-478.994

Our AMA will:

(1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT);

(2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT;

(3) support initiatives to ensure interoperability among all HIT systems; and

(4) support the indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of Electronic Health Record (EHR) products and services, and will advocate for federal regulatory reform that will allow for indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of EHR products and services.

National Health Information Technology D-478.995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability

Medical Care Online H-478.996

It is the policy of the AMA to support efforts to address the economic, literacy, and cultural barriers to patients utilizing information technology.

Enabling a Contiguous, National Electronic Health Record Network 315.003MSS

AMA-MSS (1) supports collaboration with appropriate federal government agencies and industry partners to develop and promote legislative and policy initiatives that require the interoperability of independent healthcare systems such that electronic health records data be entirely transferable; and (2) will ask the AMA to study private and public sector initiatives regarding efforts to establish a nationwide health information network and other relevant interoperability initiatives. (MSS Res 12, A-13)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 26
(A-17)

Introduced by: Aneesha Cheedalla, Allison Haley, Lochan Shah, and Rafa Rahman,
Johns Hopkins University School of Medicine

Subject: Increase Access to HIV PrEP for At-Risk Individuals

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

- 1 Whereas, 30,000 individuals are newly diagnosed with HIV every year and HIV PrEP can
2 reduce HIV transmission by up to 92%;^{1,2} and
3
4 Whereas, HIV PrEP is part of the US National HIV/AIDS Strategy (NHAS) and recommended by
5 the CDC for individuals with HIV-infected partners, homosexual or bisexual men with a recent
6 STI diagnosis, and intravenous drug users (IDU);^{1,3,4} and
7
8 Whereas, Men who have sex with men (MSM) prefer receiving HIV PrEP from clinicians
9 involved in primary care but are not offered PrEP in said care;⁵ and
10
11 Whereas, PrEP education and prescription can be effective in settings where male sex workers
12 (MSWs) already see providers, such as emergency visits, substance use clinics, mental health
13 clinics, correctional facilities, and HIV testing centers;⁵ and
14
15 Whereas, Because of stigma, medical mistrust, and perceived racism, disparities exist in HIV
16 PrEP access, resulting in black individuals using PrEP less often than their white counterparts
17 despite having the highest rates of HIV infection;^{6,7} and
18
19 Whereas, One study found that only 15% of MSM PrEP candidates in Atlanta, Georgia are
20 projected to receive PrEP because of barriers in awareness, access, prescribing practices, and
21 adherence;⁸ and
22
23 Whereas, Extensive efforts have not been made to increase availability of PrEP into HIV
24 prevention approaches for IDU populations;⁹ and
25
26 Whereas, It is possible the same methods used to motivate PrEP use in MSM populations could
27 be translated to IDU populations;⁹ and
28
29 Whereas, 26% of primary care physicians report lower willingness to prescribe PrEP to IDU
30 than to other high risk groups;¹⁰ and
31
32 Whereas, Needle exchange programs can better connect drug users to supportive services they
33 may not have received otherwise;¹¹⁻¹² and
34

1 Whereas, The United States has the highest prison population rate in the world, with over 6
2 million persons in correctional facilities in 2015 and HIV prevalence and transmission rates are
3 elevated in prison populations;¹³⁻¹⁴ and

4 Whereas, The CDC calls for HIV prevention efforts of incarcerated people in prisons and jails,
5 such as condom distribution, demonstrating the need to decrease HIV transmission in
6 incarcerated populations,¹⁵ and

7
8 Whereas, Existing AMA policy “supports the coverage of PrEP in all clinically appropriate
9 circumstances” (H-20.895) and “Encourages the inclusion of HIV-prevention information as a
10 regular part of correctional staff and inmate education” (H-430.988); therefore be it

11
12 RESOLVED, That our AMA-MSS reaffirm H-20.895; and be it further

13
14 RESOLVED, That our AMA-MSS support PrEP referral at needle exchange sites; and be it
15 further

16
17 RESOLVED, That our AMA-MSS conduct a study on the incidence of HIV in US federal, state,
18 and/or local prisons, to elucidate the need for HIV PrEP in incarcerated populations.

Fiscal Note: TBD

Date Received: 04/20/2017

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- 14) US Correctional Population at Lowest Level Since 2002. <https://www.bjs.gov/content/pub/press/cpus15pr.cfm> Published December 29, 2016. Accessed April 2, 2017.
- 15) HIV among incarcerated populations. <https://www.cdc.gov/hiv/group/correctional.html> Published March 14, 2017. Accessed April 2, 2017.

RELEVANT AMA AND AMA-MSS POLICY:

Pre-Exposure Prophylaxis for HIV H-20.895

Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV, including use in women and minority populations, and the US PrEP Clinical Practice Guidelines. 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.

Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities H-430.988

Medical Testing and Care of Prisoners a) Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes voluntary testing for HIV infection and mandatory testing for tuberculosis followed by appropriate treatment for those infected; b) During incarceration, prisoners should be tested for HIV infection as medically indicated or on their request; c) All inmates and staff should be screened for tuberculosis infection and retested at least annually. If an increase in cases of tuberculosis or HIV infection is noted, more frequent retesting may be indicated; d) Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate; e) During their post-test counseling procedures, HIV-infected inmates should be encouraged to confidentially notify their sexual or needle-sharing partners; and f) Correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. Prisoners should have access to approved therapeutic drugs and generally employed treatment strategies. (2) HIV/AIDS Education and Prevention Our AMA: a) Encourages the inclusion of HIV-prevention information as a regular part of correctional staff and inmate education. AIDS education in state and federal prisons should stress abstinence from drug use and high-risk sexual practices, as well as the proper use of condoms as one way of decreasing the spread of HIV; b) Will pursue legislation that encourages state, local, and federal correctional institutions to make condoms available to inmates; and c) Urges medical personnel in correctional institutions to work closely with state and local health department personnel to control the spread of HIV/AIDS, tuberculosis, and other serious infectious diseases within and outside these facilities. (3) Prison-based HIV Partner Notification Program Our AMA: a) Urges state health departments to take steps to initiate with state departments of correctional services the development of prison-based HIV

Partner Notification Programs for inmates convicted of drug-related crimes and their regular sexual partners; and b) Believes that all parties should recognize that maximum effectiveness in an HIV Partner Notification Program will depend on the truly voluntary participation of inmates and the strict observance of confidentiality at all levels.

Disease Prevention and Health Promotion in Correctional Institutions H-430.989

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

HIV/AIDS as a Global Public Health Priority H-20.922

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA: (1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic; (2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates; (3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease; (4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care; (5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts; (6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through prostitutes; (7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions; and (8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic. (9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.

Prevalence of HIV in Minority Populations H-20.897

Our AMA supports the Centers for Disease Control and Prevention in its efforts to evaluate the effectiveness of existing HIV prevention programs directed toward minority populations.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 27
(A-17)

Introduced by: Region 1; Region 2; Region 3; Region 4; Region 6; Yeahwa Hong, University of Toledo College of Medicine; Abhishek Desai, Boston University School of Medicine

Subject: Disaggregation of Data Concerning the Status of Asian-Americans

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, The pan-ethnic, umbrella term "Asian-American" masks the significant disparities in
2 health outcomes and socioeconomic realities, especially in individuals from Laotian,
3 Cambodian, Indonesian, and other backgrounds;^{1,2,3} and
4

5 Whereas, Overall, data on health conditions for Southeast Asian communities have not been as
6 revealing on the state or federal level, possibly due to low numbers of individuals being
7 studied;^{3,4} and
8

9 Whereas, Southeast Asians have lesser access to healthcare services compared to their White
10 or English-speaking counterparts, and Southeast Asian women participate less in health
11 screenings compared to their White counterparts;⁵ and
12

13 Whereas, While Chinese American and Asian Indian Americans experience relatively low
14 aggregate poverty rates, at 12.2% and 8.5% respectively, the ethnic groups with the most
15 people in poverty in 2010 were Chinese Americans, with 449,356 people living in poverty, and
16 Asian Indian Americans, with 246,399 people living in poverty, primarily due to the large size of
17 their populations;⁶ and
18

19 Whereas, The 2006 to 2010 aggregate poverty rate by population group was reported as 65%
20 of Bhutanese Americans, 27% for Hmong Americans, and 21% for Bangladeshi Americans;^{6,7,8}
21 and
22

23 Whereas, Among the 281,000 Hmong in the United States, 38% have less than a high school
24 degree, about 25 percentage points lower than both the Asian-American and U.S. averages,
25 and just 14% have at least a bachelor's degree, less than half the national average;⁹ and
26

27 Whereas, The homogenization of Asian-American populations undermines efforts for increased
28 inclusion and representation of students from under-represented Asian countries and cultures;^{7,10}
29 and
30

31 Whereas, AB-1726 became law in California, requiring that the Department of Public Health
32 collect disaggregate demographic data to better expose disparities in healthcare for Pacific
33 Islanders and Southeast Asians, serving as an example for other states to model;¹⁰ and
34

35 Whereas, Although the Association of American Medical Colleges defines Underrepresented in
36 Medicine as African-Americans, Latinos, and Native Americans, Southeast Asian groups,

1 including individuals from Hmong, Cambodian, and Laotian American backgrounds, also face
2 disparities within the pipeline to medicine and are considered underrepresented relative to other
3 ethnic groups;¹¹ and

4
5 Whereas, Cultural diversity brings strength to the healthcare team due to the presence of a
6 multiplicity of perspectives and therefore competency in serving a wide range of patient
7 populations;¹² and

8
9 Whereas, Current AMA policies **H-350.970** and **H-350.960** encourage medical schools to
10 outreach and support minority students, which do not traditionally include Southeast Asians, and
11 policy **H-350.966** asks agencies and institutions to improve public health data collection on
12 Asian Americans but not the disaggregation of this data; therefore be it

13
14 RESOLVED, That our AMA advocates for the disaggregation of data regarding Asian-
15 Americans in order to reveal the within-group disparities that exist in health outcomes and
16 representation in medicine.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Medical Education for Members in Underserved Minority Populations H-350.969

Our AMA: (1) actively opposes the reduction of resources and opportunities used to increase the number of minority medical and premedical students in training; (2) uses its influence in states and local communities to increase the representation of minority group members in medical education, as long as domestic health care disparities exist between minority populations and the greater population at-large; and (3) supports the need for an increase in the participation of under-represented minorities as investigators, trainees, reviewers, and subjects in peer review biomedical research at all levels. Reaffirmed in lieu of Res. 311, A-15

Underrepresented Student Access to US Medical Schools H-350.960

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students. Reaffirmed in lieu of Res. 311, A-15

Reducing Racial and Ethnic Disparities in Health Care D-350.995

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

- (1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
- (2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
- (3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities. Reaffirmation: A-16

Health Initiatives on Asian-Americans and Pacific Islanders H-350.966

Our AMA urges existing federal agencies, commissions and Asian American and Pacific Islander health organizations to study how to improve the collection, analysis and dissemination of public health data on Asian Americans and Pacific Islanders. Reaffirmed: CSAPH Rep. 1, A-10

Diversity in Medical Education H-350.970

Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other

relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion. Reaffirmed in lieu of Res. 311, A-15

Improving the Health of Black and Minority Populations H-350.972

Our AMA supports:

- (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
- (2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
- (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
- (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis. Modified: CSAPH Rep. 1, A-11

Racial and Ethnic Disparities in Health Care H-350.974

Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

The AMA emphasizes three approaches that it believes should be given high priority:

- (1) Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
- (2) Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
- (3) Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decisionmaking process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA

supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. Reaffirmed: BOT Rep. 4, A-03

Minorities in the Health Professions H-350.978

The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.

(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.

(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.

(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.

(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.

(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.

(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.

(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program. Reaffirmed: CLRPD Rep. 1, A-08

Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities D-350.991

Our AMA: (1) in collaboration with the National Medical Association and the National Hispanic Medical Association, will distribute the Guiding Principles document of the Commission to End Health Care Disparities to all members of the federation and encourage them to adopt and use these principles when addressing policies focused on racial and ethnic health care disparities; (2) shall work with the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities; 3) urges medical societies that are not yet members of the Commission to End Health Care Disparities to join the Commission, and 4) strongly encourages all medical societies to form a Standing Committee to Eliminate Health Care Disparities. Appended: Res. 416, A-11

Addressing Immigrant Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees. Appended: Res. 409, A-15

Improving the Health of Minority Populations H-350.961

Our AMA urges Congress to re-evaluate and expand the federal race and ethnicity categories to include additional ethnic subgroups in order to analyze and uncover racial and ethnic health and healthcare disparities. Res. 906, I-08

Cancer and Health Care Disparities Among Minority Women D-55.997

Our AMA: (1) encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment; and (2) will work with the National Cancer Institute's Center to Reduce Cancer Health Disparities, the American Cancer Society, and other organizations to promote the use among minority women of educational materials that are culturally sensitive and at the appropriate literacy level. Res. 509, A-08

Strategies for Eliminating Minority Health Care Disparities D-350.996

Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate. Modified: CCB/CLRPD Rep. 4, A-12

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 28
(A-17)

Introduced by: Region 2

Subject: Reducing Nicotine Content In Cigarettes

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Tobacco use increases the risk of countless diseases, namely cancer (especially
2 lung, esophagus, larynx, kidney, bladder, liver, pancreas, stomach, cervix, colorectal, and acute
3 myeloid leukemia), chronic obstructive pulmonary disease, coronary artery disease, and
4 stroke;^{1,2} and

5
6 Whereas, Over the past 50 years, tobacco control in the US has led to an estimated 8 million
7 fewer premature deaths;^{1,3} and

8
9 Whereas, Tobacco use continues to significantly affect public health, as 36.5 million adults in
10 America still smoke and nearly 500,000 annual deaths in America are attributed to tobacco,
11 including 167,133 cancer deaths;^{1,4-6} and

12
13 Whereas, Nicotine is a highly addictive component of cigarettes and is chiefly responsible for
14 addiction to and maintenance of cigarette smoking;⁷⁻¹⁰ and

15
16 Whereas, While adolescents and young adults may have a general awareness of the risks of
17 cigarette smoking, they underestimate the harm and the addictive nature of cigarette
18 smoking;^{11,12} and

19
20 Whereas, One potential way to address the tobacco public health crisis is to reduce the nicotine
21 content of cigarettes to non-addicting levels, which could prevent individuals from becoming
22 addicted;¹³⁻¹⁵ and

23
24 Whereas, Most manufactured cigarettes contain 10-15 mg of nicotine per cigarette, and a
25 smoker typically absorbs 10% of the nicotine contained in the cigarette, with a typical systemic
26 intake of 1–2 mg of nicotine per cigarette;¹⁶ and

27
28 Whereas, It is estimated that reducing the total nicotine content of cigarettes to 0.1-0.5 mg per
29 rod would minimize the addictiveness of cigarettes;^{13,14} and

30
31 Whereas, Previous attempts at “light,” “low,” or “mild” cigarettes (“low yield” cigarettes) have
32 been made in the past by adjusting cigarette filters, ventilation holes, and additives to hasten the
33 speed of cigarette burning;^{17,18} and

34
35 Whereas, Use of these “low yield” cigarettes resulted in a compensatory change in the way
36 cigarettes were smoked, such as increasing the number of cigarettes smoked, taking more and
37 deeper puffs, and blocking ventilation holes, and the smokers of these cigarettes were exposed
38 to the same levels of toxicants compared to regular cigarettes;^{17,18} and

1
2 Whereas, In contrast to these “low yield” cigarettes that generate low yields in machine tests
3 due to design features but do not usually involve reducing the nicotine content of the cigarette,
4 low-nicotine cigarettes the nicotine content of the cigarette tobacco, and compensation is much
5 more difficult and could only be achieved by smoking a greater number of cigarettes to the point
6 that it would become infeasible or even impossible to spend enough time smoking in a
7 day;^{7,13,19,20} and
8

9 Whereas, Four clinical trials of reduced nicotine content cigarettes demonstrated that switching
10 to these reduced content cigarettes resulted in a decrease in nicotine intake with no significant
11 change in cigarettes smoked per day or toxicant exposure, suggesting that compensation does
12 not occur with reduced nicotine content cigarettes, unlike “low yield” cigarettes;²¹⁻²⁴ and
13

14 Whereas, In one of these randomized trials done with individuals interested in quitting, the
15 nicotine content was reduced to either 0.05mg or 0.3mg, and the 0.05mg group demonstrated a
16 greater rate of smoking cessation; and
17

18 Whereas, Two other studies have also found that there is little or no compensation after
19 switching from regular to reduced nicotine content cigarettes;^{25,26} and
20

21 Whereas, The Food and Drug Administration (FDA) was given the authority to regulate cigarette
22 nicotine content through the Family Smoking Prevention and Tobacco Control Act, although it
23 cannot reduce nicotine content to zero;²⁷ therefore be it
24

25 RESOLVED, That our AMA advocate for federal regulation to reduce the nicotine content in all
26 cigarettes to non-addicting levels in order to prevent individuals from becoming addicted to
27 cigarettes and to assist addicted smokers with quitting.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

H-495.986 Tobacco Product Sales and Distribution

Our AMA: (1) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors; (2) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age; (3) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors; (4) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products; (5) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products; (6) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail; (7) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; (8) opposes the sale of tobacco at any facility where health services are provided; and (9) supports that the sale of tobacco products be restricted to tobacco specialty stores.

H-495.984 Tobacco Advertising and Media

Our AMA:

(1) in keeping with its long-standing objective of protecting the health of the public, strongly supports a statutory ban on all advertising and promotion of tobacco products;

(2) as an interim step toward a complete ban on tobacco advertising, supports the restriction of tobacco advertising to a "generic" style, which allows only black-and-white advertisements in a standard typeface without cartoons, logos, illustrations, photographs, graphics or other colors;

(3) (a) recognizes and condemns the targeting of advertisements for cigarettes and other tobacco products toward children, minorities, and women as representing a serious health hazard; (b) calls for the curtailment of such marketing tactics; and (c) advocates comprehensive legislation to prevent tobacco companies or other companies promoting look-alike products designed to appeal to children from targeting the youth of America with their strategic marketing programs;

(4) supports the concept of free advertising space for anti-tobacco public service advertisements and the use of counter-advertising approved by the health community on government-owned property where tobacco ads are posted;

(5) (a) supports petitioning appropriate government agencies to exercise their regulatory authority to prohibit advertising that falsely promotes the alleged benefits and pleasures of smoking as well worth the risks to health and life; and (b) supports restrictions on the format and content of tobacco advertising substantially comparable to those that apply by law to prescription drug advertising;

(6) publicly commends those publications that have refused to accept cigarette advertisements and supports publishing annually, via JAMA and other appropriate publications, a list of those magazines that have voluntarily chosen to decline tobacco ads, and circulation of a list of those publications to every AMA member;

(7) urges physicians to mark the covers of magazines in the waiting area that contain tobacco advertising with a disclaimer saying that the physician does not support the use of any tobacco products and encourages physicians to substitute magazines without tobacco ads for those with tobacco ads in their office reception areas;

(8) urges state, county, and specialty societies to discontinue selling or providing mailing lists of their members to magazine subscription companies that offer magazines containing tobacco advertising;

(9) encourages state and county medical societies to recognize and express appreciation to any broadcasting company in their area that voluntarily declines to accept tobacco advertising of any kind;

(10) urges the 100 most widely circulating newspapers and the 100 most widely circulating magazines in the country that have not already done so to refuse to accept tobacco product advertisements, and continues to support efforts by physicians and the public, including the use of written correspondence, to persuade those media that accept tobacco product advertising to refuse such advertising;

(11) (a) supports efforts to ensure that sports promoters stop accepting tobacco companies as sponsors; (b) opposes the practice of using athletes to endorse tobacco products and encourages voluntary cessation of this practice; and (c) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products;

(12) will communicate to the organizations that represent professional and amateur sports figures that the use of all tobacco products while performing or coaching in a public athletic event is unacceptable. Tobacco use by role models sabotages the work of physicians, educators, and public health experts who have striven to control the epidemic of tobacco-related disease;

(13) (a) encourages the entertainment industry, including movies, videos, and professional sporting events, to stop portraying the use of tobacco products as glamorous and sophisticated and to continue to de-emphasize the role of smoking on television and in the movies; (b) will aggressively lobby appropriate entertainment, sports, and fashion industry executives, the media and related trade associations to cease the use of tobacco products, trademarks and logos in their activities, productions, advertisements, and media accessible to minors; and (c) advocates comprehensive legislation to prevent tobacco companies from targeting the youth of America with their strategic marketing programs; and

(14) encourages the motion picture industry to apply an "R" rating to all new films depicting cigarette smoking and other tobacco use.

H-490.914 Tobacco Prevention and Youth

Our AMA:

- (1) (a) urges the medical community, related groups, educational institutions, and government agencies to demonstrate more effectively the health hazards inherent in the use of tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco); (b) encourages state and local medical societies to actively advise municipalities and school districts against use of health education material sponsored or distributed by the tobacco industry; and (c) publicly rejects the tobacco industry as a credible source of health education material;
- (2) opposes the use of tobacco products of any kind in day care centers or other establishments where pre-school children attend for educational or child care purposes;
- (3) advises public and private schools about the very early smoking habits observed in children and encourages appropriate school authorities to prohibit the use of all tobacco products in elementary through senior high school by anyone during the school day and during other school-related activities;
- (4) (a) supports the concept that a comprehensive health education program stressing health maintenance be part of the required curriculum through 12th grade to: (i) help pre-teens, adolescents, and young adults avoid the use of tobacco products, including smokeless tobacco; and (ii) emphasize the benefits of remaining free of the use of tobacco products; (b) will work with other public and private parties to actively identify and promote tobacco prevention programs for minors and encourages the development, evaluation, and incorporation of appropriate intervention programs, including smoking cessation programs, that are tailored to the needs of children; and (c) recommends that student councils and student leaders be encouraged to join in an anti-smoking campaign.
- (5) urges state medical societies to promote the use of appropriate educational films and educational programs that reduce tobacco use by young people;
- (6) (a) favors providing financial support to promising behavioral research into why people, especially youth, begin smoking, why they continue, and why and how they quit; (b) encourages research into further reducing the risks of cigarette smoking; and (c) continues to support research and education programs, funded through general revenues and private sources, that are concerned with health problems associated with tobacco and alcohol use;
- (7) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products, as youth are particularly susceptible;
- (8) supports working with appropriate organizations to develop a list of physicians and others recommended as speakers for local radio and television to discuss the harmful effects of tobacco usage and to advocate a tobacco-free society; and
- (9) commends the following entities for their exemplary efforts to inform the Congress, state legislatures, education officials and the public of the health hazards of tobacco use: American Cancer Society, American Lung Association, American Heart Association, Action on Smoking and Health, Inc., Groups Against Smoker's Pollution, National Congress of Parents and Teachers, National Cancer Institute, and National Clearinghouse on Smoking (HEW).

D-490.998 Tobacco Control and Settlement

Our AMA: (1) will undertake action to publicize, support and implement the elements of its policies that have not been adequately addressed by the Master Settlement Agreement and other agreements, including but not limited to:

- (a) A complete ban on tobacco industry promotion and advertising;

- (b) Regulation of tobacco sales, including a ban on vending machines and a mandate for behind the counter sales;
- (c) Tax increases on tobacco products;
- (d) Protection from environmental tobacco smoke;
- (e) Regulation of nicotine as a drug by the Food and Drug Administration; and
- (f) Look back provisions; and

(2) will work with Congress, the Administration and other groups to achieve public health goals and accomplish the issues addressed by our AMA policies through federal and state tobacco control legislation.

H-495.981 Light and Low-Tar Cigarettes

Our AMA concurs with the key scientific findings of National Cancer Institute Monograph 13, Risks Associated with Smoking Cigarettes with Low Machine-Measured Yields of Tar and Nicotine:

- (a) Epidemiological and other scientific evidence, including patterns of mortality from smoking-caused diseases, does not indicate a benefit to public health from changes in cigarette design and manufacturing over the last 50 years.
- (b) For spontaneous brand switchers, there appears to be complete compensation for nicotine delivery, reflecting more intensive smoking of lower-yield cigarettes. (c) Cigarettes with low machine-measured yields by Federal Trade Commission (FTC) methods are designed to allow compensatory smoking behaviors that enable a smoker to derive a wide range of tar and nicotine yields from the same brand.
- (d) Widespread adoption of lower yield cigarettes in the United States has not prevented the sustained increase in lung cancer among older smokers.
- (e) Many smokers switch to lower yield cigarettes out of concern for their health, believing these cigarettes to be less risky or to be a step toward quitting; many smokers switch to these products as an alternative to quitting.
- (f) Advertising and promotion of low tar cigarettes were intended to reassure smokers who were worried about the health risks of smoking, were meant to prevent smokers from quitting based on those same concerns; such advertising was successful in getting smokers to use low-yield brands.
- (g) Existing disease risk data do not support making a recommendation that smokers switch cigarette brands. The recommendation that individuals who cannot stop smoking should switch to low yield cigarettes can cause harm if it misleads smokers to postpone serious attempts at cessation.
- (h) Measurements of tar and nicotine yields using the FTC method do not offer smokers meaningful information on the amount of tar and nicotine they will receive from a cigarette.

H-495.988 FDA Regulation of Tobacco Products

Our AMA seeks legislation or regulation to prohibit cigarette manufacturers from using deceptive terms such as "light," "ultra-light," "mild," and "low-tar" to describe their products.

1. Our AMA: (A) reaffirms its position that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (B) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (C) reaffirms its position that the Food and Drug Administration (FDA) does have, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (D) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (E) urges Congress to pass legislation to phase in the production of

less hazardous and less toxic tobacco, and to authorize the FDA have broad-based powers to regulate tobacco products; (F) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and (G) strongly opposes legislation which would undermine the FDA's authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products.

2. Our AMA: (A) supports the US Food and Drug Administration (FDA) as it takes an important first step in establishing basic regulations of all tobacco products; (B) strongly opposes any FDA rule that exempts any tobacco or nicotine-containing product, including all cigars, from FDA regulation; and (C) will join with physician and public health organizations in submitting comments on FDA proposed rule to regulate all tobacco products.

H-30.958 Ethyl Alcohol and Nicotine as Addictive Drugs

The AMA (1) identifies alcohol and nicotine as drugs of addiction which are gateways to the use of other drugs by young people; (2) urges all physicians to intervene as early as possible with their patients who use tobacco products and have problems related to alcohol use, so as to prevent adverse health effects and reduce the probability of long-term addiction; (3) encourages physicians who treat patients with alcohol problems to be alert to the high probability of co-existing nicotine problems; and (4) reaffirms that individuals who suffer from drug addiction in any of its manifestations are persons with a treatable disease.

H-495.973 FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products

Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; and (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 18; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth.

H-490.917 Physician Responsibilities for Tobacco Cessation

Cigarette smoking is a major health hazard and a preventable factor in physicians' actions to maintain the health of the public and reduce the high cost of health care. Our AMA takes a strong stand against smoking and favors aggressively pursuing all avenues of educating the

general public on the hazards of using tobacco products and the continuing high costs of this serious but preventable problem. Additionally, our AMA supports and advocates for appropriate surveillance approaches to measure changes in tobacco consumption, changes in tobacco-related morbidity and mortality, youth uptake of tobacco use, and use of alternative nicotine delivery systems. In view of the continuing and urgent need to assist individuals in smoking cessation, physicians, through their professional associations, should assume a leadership role in establishing national policy on this topic and assume the primary task of educating the public and their patients about the danger of tobacco use (especially cigarette smoking). Accordingly, our AMA:

(1) encourages physicians to refrain from engaging directly in the commercial production or sale of tobacco products;

(2) supports (a) development of an anti-smoking package program for medical societies; (b) making patient educational and motivational materials and programs on smoking cessation available to physicians; and (c) development and promotion of a consumer health-awareness smoking cessation kit for all segments of society, but especially for youth;

(3) encourages physicians to use practice guidelines for the treatment of patients with nicotine dependence and will cooperate with the Agency for Health Research and Quality (AHRQ) in disseminating and implementing evidence-based clinical practice guidelines on smoking cessation, and on other matters related to tobacco and health;

(4) (a) encourages physicians to use smoking cessation activities in their practices including (i) quitting smoking and urging their colleagues to quit; (ii) inquiring of all patients at every visit about their smoking habits (and their use of smokeless tobacco as well); (iii) at every visit, counseling those who smoke to quit smoking and eliminate the use of tobacco in all forms; (iv) prohibiting all smoking in the office by patients, physicians, and office staff; and discouraging smoking in hospitals where they work (v) providing smoking cessation pamphlets in the waiting room; (vi) becoming aware of smoking cessation programs in the community and of their success rates and, where possible, referring patients to those programs; (b) supports the concept of smoking cessation programs for hospital inpatients conducted by appropriately trained personnel under the supervision of a physician;

(5) (a) supports efforts to identify gaps, if any, in existing materials and programs designed to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (b) supports the production of materials and programs which would fill gaps, if any, in materials and programs to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (c) supports national, state, and local efforts to help physicians and medical students develop skills necessary to counsel patients to quit smoking; (d) encourages state and county medical societies to sponsor, support, and promote efforts that will help physicians and medical students more effectively counsel patients to stop smoking; (e) encourages physicians to participate in education programs to enhance their ability to help patients quit smoking; (f) encourages physicians to speak to community groups about tobacco use and its consequences; and (g) supports providing assistance in the promulgation of information on the effectiveness of smoking cessation programs;

(6) (a) supports the concept that physician offices, clinics, hospitals, health departments, health plans, and voluntary health associations should become primary sites for education of the public about the harmful effects of tobacco and encourages physicians and other health care workers to introduce and support healthy lifestyle practices as the core of preventive programs in these

sites; and (b) encourages the development of smoking cessation programs implemented jointly by the local medical society, health department, and pharmacists; and

(7) (a) believes that collaborative approaches to tobacco treatment across all points of contact within the medical system will maximize opportunities to address tobacco use among all of our patients, and the likelihood for successful intervention; and (b) supports efforts by any appropriately licensed health care professional to identify and treat tobacco dependence in any individual, in the various clinical contexts in which they are encountered, recognizing that care provided in one context needs to take into account other potential sources of treatment for tobacco use and dependence.

490.008MSS Regulation of Tobacco Products by the Food and Drug Administration

AMA-MSS will ask the AMA to support the regulation of tobacco products by the Food and Drug Administration. (AMA Res 243, A-89, Adopted [490.962]) (Reaffirmed: MSS Rep D, I-99)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 29
(A-17)

Introduced by: Taylor Lucas, University of South Carolina School of Medicine
Greenville; Kevin Qin, University of Toledo College of Medicine
and Life Sciences; Gabe Pham, University of Cincinnati College of
Medicine; Rachel Ekaireb, University of California San Francisco

Subject: Opposition to Medicaid work requirements

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, The Medicaid program has been steadily growing over the past three years
2 and currently provides health insurance for over 70,000,000 Americans, including
3 children, impoverished families and those with disabilities;¹ and
4
5 Whereas, An estimated 1.75 million full-time students are currently enrolled in the
6 Medicaid program and are not working;² and
7
8 Whereas, Arizona, Kentucky, and, Pennsylvania have formally submitted Section 1115
9 state waiver requests to include work requirements for Medicaid eligibility;³ and
10
11 Whereas, Several other states have proposed or are in the process of proposing similar
12 work requirements for Medicaid;³ and
13
14 Whereas, The Centers for Medicare and Medicaid Services has indicated support for
15 Section 1115 state waiver initiatives involving “training, employment and
16 independence”;⁴ and
17
18 Whereas, Studies have found that Medicaid expansion has had a positive or neutral
19 effect on employment and the labor market;^{5,6}
20
21 Whereas, Most new Medicaid enrollees in Ohio looking for work reported that having
22 Medicaid coverage was advantageous to their job search;^{7,8}
23
24 Whereas, The majority of Ohio expansion enrollees who were employed reported that
25 Medicaid enrollment made it easier to continue working;^{7,8} and
26
27 Whereas, Implementation of work requirements would expand the administrative cost of
28 the Medicaid program per enrollee for states as it has in other programs;^{3,9,10} and
29
30 Whereas, Imposition of a work requirement has been shown to have only a modest
31 benefit to employment that decreases over time when implemented in other programs;^{9,}
32 ¹¹ and
33

1 Whereas, An estimated 3.43 million non-SSI Medicaid recipients report being too sick to
2 work;² and

3
4 Whereas, An estimated 2.74 million non-SSI Medicaid recipients report they couldn't
5 work because of taking care of their home or family;² and

6
7 Whereas, A work requirement as a criterion for Medicaid eligibility could bar access to
8 healthcare from vulnerable people too sick to work, acting as caregivers, or unable to
9 find employment;² therefore be it

10
11 RESOLVED, That our American Medical Association (AMA) oppose work requirements
12 as a criterion for Medicaid eligibility.

Fiscal Note: TBD

Date Received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Proposed Revisions to AMA Policy on Medical Student Debt H-305.928 –

Medical students should not be forced to jeopardize their education by the need to seek employment. Any decision on the part of the medical student to seek employment should take into account his/her academic situation. Medical schools should have policies and procedures in place that allow for flexible scheduling in the case that medical students encounter financial difficulties that can be remedied only by employment. Medical schools should consider creating opportunities for paid employment for medical students.

Medicaid Expansion Options and Alternatives H-290.966 –

1. Our AMA encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap.
2. Our AMA encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low income adult populations.
3. Our AMA encourages the Centers for Medicare & Medicaid Services to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults.
4. Our AMA advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid website.

Medicaid - Towards Reforming the Program H-290.997 -

Our AMA believes that greater equity should be provided in the Medicaid program, through adoption of the following principles:

- (1) the creation of basic national standards of uniform eligibility for all persons below poverty level income (adjusted by state per capita income factors);
- (2) the creation of basic national standards of uniform minimum adequate benefits;
- (3) the elimination of the existing categorical requirements;
- (4) the creation of adequate payment levels to assure broad access to care; and
- (5) establishment of national standards that result in uniform eligibility, benefits and adequate payment mechanisms for services across jurisdictions.

Giving States New Options to Improve Coverage for the Poor D-165.966 –

Our AMA will (1) advocate that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes, including

combining refundable, advanceable tax credits inversely related to income to purchase health insurance coverage with converting Medicaid from a categorical eligibility program to one that allows for coverage of additional low-income persons based solely on financial need; (2) advocate for changes in federal rules and federal financing to support the ability of states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds; and (3) continue to work with interested state medical associations, national medical specialty societies, and other relevant organizations to further develop such state-based options for improving health insurance coverage for low-income persons.

Medicaid Expansion D-290.979 –

Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.

Affordable Care Act Medicaid Expansion H-290.965 –

1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.

12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.

13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.

Recognizing Dependent Care Expenses in Determining Graduate Medical Education Financial Aid 305.041MSS

AMA-MSS will ask the AMA to pursue legislation to change the cost of attendance definition to include costs for food, shelter, clothing, health care, and dependent care for all dependents.

Medical Education Financial Aid 305.049MSS

(1) AMA-MSS will ask the AMA to: (a) work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent health insurance, dependent care, and dependent living expenses be included both as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid in medical schools; (b) encourage medical schools to include dependent health insurance, dependent care, and dependent living expenses as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid; and (c) ask its Council on Medical Education, Section on Medical Schools, and Women's Physician Congress to consider alternative methods to carry out the intentions of current HOD policy on the issue of dependent health insurance, dependent care, and dependent living expenses; (2) AMA-MSS supports the inclusion of dependent care, health insurance, and living expenses in medical student financial aid budgets.

Recognizing Spousal Care Expenses in Determining Medical Education Financial Aid 305.050MSS

AMA-MSS supports the inclusion of spousal health insurance in medical student financial aid budgets and encourages medical schools to include spousal and same-sex spousal equivalent health insurance as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid.

Medicaid Reform and Coverage for the Uninsured: Beyond Tax Credits 165.011MSS

AMA-MSS will: (1) actively support the ongoing efforts of the AMA to reform Medicaid in order to increase access to health care among the uninsured and underinsured of our nation; (2) support the ongoing AMA efforts to implement graduated, refundable tax credits as a replacement for Medicaid; (3) make the active promotion and education of the AMA plan for health insurance reform a top priority; (4) work with the AMA to create and fund programming that will educate both physicians and patients about the AMA plan for insurance reform and publicize that plan to the general public.

Covering the Uninsured as AMA's Top Priority 165.012MSS

AMA-MSS will ask the AMA to make the number one priority of the American Medical Association comprehensive health system reform that achieves reasonable health insurance for all Americans and that emphasizes prevention, quality, and safety while addressing the broken medical liability system, flaws in Medicare and Medicaid, and improving the physician practice environment.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 30
(A-17)

Introduced by: Region 1; Steven Young, Tufts University School of Medicine; Hannah Chen, Baylor College of Medicine; Ruth Howe, Albert Einstein College of Medicine; Hayden Pacl, University of Alabama at Birmingham School of Medicine; Nithya Vijayakumar, University of Michigan Medical School; Manna Varghese, University of Missouri Kansas City School of Medicine; Lauren Benning, Campbell University School of Osteopathic Medicine

Subject: Federal Agricultural Subsidy Reform

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, The United States Department of Agriculture (USDA) administers federal agricultural
2 subsidies, which are embodied in statute and legislation in the most recent 2014 Farm Bill;¹ and
3
4 Whereas, The commodity crops subsidized by the federal government-- predominantly corn,
5 soybeans, wheat, and cotton--have remained largely unchanged since the introduction of
6 subsidies in 1933, despite accumulating data on adverse public health outcomes;¹ and
7
8 Whereas, Subsidies for corn, the most heavily subsidized crop in 2014, have more than doubled
9 in the past decade, increasing a total of \$94 billion between 1995 and 2014.;² and
10
11 Whereas, Subsidized corn crops are grown, processed, and sold for a number of uses,
12 including conversion to oils (50% of subsidized corn crops), livestock feed (30-40%), and
13 conversion into high fructose corn syrup (5%);⁴⁻⁵ and
14
15 Whereas, Multiple sources show over the past 4 decades the price of products containing
16 subsidized corn products, especially those containing high fructose corn syrup like soft drinks,
17 have decreased in price while the price of fresh fruits and vegetables has increased;^{3,5-6,11} and
18
19 Whereas, Between 1982 and 2000, the per capita consumption of corn products increased at
20 double the rate of the increase in the consumption of fresh fruits and vegetables;^{10,11} and
21
22 Whereas, Between 1985 and 2000 the real price of fresh fruits and vegetables have increased
23 over 40% while the price of soft drinks has decreased over 20%;^{10,11} and
24
25 Whereas, Evidence shows individuals that consume foods containing subsidized products
26 (including notably corn products like high fructose corn syrup) have a higher risk of being obese
27 and at risk for developing diabetes, metabolic syndrome, and hyperlipidemia;^{4,12,13} and
28
29 Whereas, Research shows that choosing more whole grains, fresh fruits, and vegetables has
30 many health benefits, including reducing all causes of mortality, such as cancer and
31 cardiovascular disease, as well as reducing the risk of contracting major illnesses, such as
32 coronary vascular disease;¹³ and
33

1 Whereas, No farm bill has ever been introduced to subsidize fresh fruits and vegetables;¹ and

2
3 Whereas, The USDA via the Farm Bill is indirectly at odds with its mission to promote health
4 and nutrition in its collaboration with the Department of Health and Human Services by creating
5 economic incentives favoring the production of oils, grains, and meats over fruits and
6 vegetables, which has contributed to the diabetes, obesity, and metabolic syndrome epidemics
7 afflicting the US,^{1-4,7,9-13,15} and

8
9 Whereas, Our AMA-MSS has formally established support for AMA policy (H-150.944) that
10 supports ensuring federal subsidies encourage the consumption of products low in fat and
11 cholesterol (MSS Res 33, I-13); and

12
13 Whereas, Our AMA and AMA-MSS have established support for consumer-level interventions
14 and education about the effects of excessive dietary sugars (H-150.960, H-150.974, H-150.945,
15 D-150.975, D-150.987); and

16
17 Whereas, Our AMA supported the creation of an advisory board to review and recommend US
18 Farm Bill budget allocations to ensure any government subsidies are only used to help produce
19 healthy food choices and sustainable foods (H-150.932); and therefore be it

20
21 RESOLVED, That our AMA MSS support efforts to limit the consumption of foods and
22 beverages that contain added sweeteners by ending federal agricultural subsidies for the
23 production of high fructose corn syrup; and be it further

24
25 RESOLVED, That our AMA-MSS support the adjustment of federal subsidies toward the
26 preferential subsidization of crops and food products that are consistent with evidence based
27 guidelines for good nutrition and healthy eating patterns.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

H-150.932 Reform the US Farm Bill to Improve US Public Health and Food Sustainability:

Our AMA supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders.

H-150.933 Taxes on Beverages with Added Sweeteners

1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages containing added sweeteners. Taxes on beverages with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic.
2. Where taxes on beverages with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately effected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes.
3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages, particularly in children and adolescents.

H-150.945 Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-Food and Other Chain Restaurants

Our AMA:

1. supports federal, state, and local policies to require fast-food and other chain restaurants with 10 or more units (smaller, neighborhood restaurants could be exempt) to provide consumers with nutrition information on menus and menu boards;

2. recommends that nutrition information in fast-food and other chain restaurants include calorie, fat, saturated fat and trans fat, and sodium labeling on printed menus, and, at a minimum, calories on menu boards, since they have limited space, and that all nutrition information be conspicuous and easily legible;
3. urges federal, state, and local health agencies, health organizations, and physicians and other health professionals to educate people how to use the nutrition information provided in restaurants to make healthier food choices for themselves and their families; and
4. urges restaurants to improve the nutritional quality of their menu offerings--for example, by reducing caloric content; offering smaller portions; offering more fruits, vegetables, and whole-grain items; using less sodium; using cooking fats lower in saturated and trans fats; and using less added sugars/sweeteners.

H-150.960 Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools

The AMA supports the position that primary and secondary schools should replace foods in vending machines and snack bars, which are of low nutritional value and are high in fat, salt and/or sugar, with healthier food choices which contribute to the nutritional needs of the students.

D-150.974 Support for Nutrition Label Revision and FDA Review of Added Sugar

1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period.
2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA).
3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.

D-150.975 Eligibility of Sugar-Sweetened Beverages for SNAP

Our AMA will: (1) publish an educational brief to educate physicians about the effects of sugar-sweetened beverages (SSBs) on obesity and overall health, and encourage them to educate their patients in turn, (2) encourage state health agencies to include educational materials about nutrition and healthy food and beverage choices in routine materials that are currently sent to Supplemental Nutrition Assistance Program (SNAP) recipients along with the revised eligible foods and beverages guidelines, and (3) work to remove SSBs from SNAP.

D-150.981 The Health Effects of High Fructose Corn Syrup

Our AMA:

- (1) recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS;
- (2) encourages independent research (including epidemiological studies) on the health effects of HFCS and other sweeteners, and evaluation of the mechanism of action and relationship between fructose dose and response; and
- (3) in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added caloric sweeteners in their diet.

D-150.987 Addition of Alternatives to Soft Drinks in Schools

Our AMA will seek to promote the consumption and availability of nutritious beverages as a healthy alternative to high-calorie, low nutritional-content beverages (such as carbonated sodas and sugar-added juices) in schools.

150.020MSS Decreasing Incidence of Obesity and Negative Sequelae by Reducing the Cost Disparity Between Calorie-Dense, Nutrition Poor Foods and Nutrition-Dense Foods

AMA-MSS will ask the AMA to (1) support efforts to decrease the price gap between calorie dense, nutrition poor (CDNP) foods and naturally nutrition dense (ND) foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrolment, of existing programs that seek to improve nutrition and reduce obesity such as the Farmer's Market Nutrition Program (FMNP) as a part of the Women, Infants, and Children (WIC) program; and (2) support the novel application of FMNP to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of ND foods in wider food distribution venues than solely farmer's markets as part of WIC.

150.022MSS Support for Fees and Taxes on Non-Alcoholic Beverages Containing Caloric Sweeteners

AMA-MSS will (1) support and advocate for legislation and policies for increased fees and/or taxes on non-alcoholic beverages containing caloric sweeteners; and (2) support the exclusive use of revenue generated from taxes on non-alcoholic beverages containing caloric sweeteners for funding of public health programs designed to combat obesity or public health programs that promote good nutrition.

150.028MSS Increasing Healthy Food Choices Among Families Supported by the Supplemental Nutrition Assistance Program

AMA-MSS will ask the AMA to advocate for positive financial incentives to encourage healthier food purchases for Supplemental Nutrition Assistance Program participants.

215.004MSS Banning the Sale of Sugar-Sweetened Beverages in Hospitals

AMA-MSS supports measures that restrict retail or vending machine sales of sugar-sweetened beverages in hospitals, clinics, or food service outlets that operate in space owned by licensed health care facilities.

The MSS formally establishes support for the following HOD policies:

H-150.944 Combating Obesity and Health Disparities

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of products low in fat and cholesterol. (Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13)

H-150.962 Quality of School Lunch Program

The AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines. (Sub. Res. 507, A-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-07)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 31
(A-17)

Introduced by: Brian Chernak, SUNY Downstate College of Medicine
Chenghao Qian, University of Kentucky School of Medicine

Subject: Investigating the Diagnosis of post-Lyme Disease Syndrome and Determining
the Validity of Alternative Therapies

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Lyme Disease is the most frequently reported tick-borne infection in the United States
2 with major complications affecting the skin, heart, joints and nervous system;¹ and
3
4 Whereas, The treatments for Lyme Disease have been clearly established by the guidelines
5 from Infectious Diseases Society of America (IDSA) with proven efficacy for both early and late
6 disease stages as well as their associated complications;¹ and
7
8 Whereas, The Centers for Disease Control acknowledge that many patients who are
9 appropriately treated for Lyme Disease experience lingering symptoms of fatigue and
10 generalized pain which can last for more than 6 months;² and
11
12 Whereas, The IDSA tentatively proposed a diagnosis of post-Lyme Disease Syndrome in 2006
13 as the symptom onset of either fatigue, diffuse musculoskeletal pain, and cognitive issues within
14 6 months of a diagnosis of Lyme Disease and presenting after acceptable antibiotic treatment,¹
15 which has remained consistent with the Swiss Society of Infectious Diseases guidelines
16 published in 2016;³ and
17
18 Whereas, This collection of symptoms has been named post-Lyme Disease Syndrome by the
19 IDSA but is frequently addressed as post-treatment Lyme Disease Syndrome by the CDC and
20 Chronic Lyme Disease by others;²⁻⁴ and
21
22 Whereas, Patients who currently fit under the diagnosis of post-Lyme Disease Syndrome
23 reported having a significant decline in their quality of life that is comparable to other chronic
24 illnesses such as congestive heart failure and fibromyalgia;⁵ and
25
26 Whereas, This condition has no true understood cause and no evidenced-based therapy which
27 has been shown to be effective in treating these symptoms, but it resolves in nearly all patients
28 over the course of many months;² and
29
30 Whereas, Recent studies investigating treatment outcomes of patients with documented
31 erythema migrans, the common sign of Lyme Disease, found that subjective symptoms such as
32 fatigue, arthralgias, and headache were as common in the patients who had been previously
33 treated for Lyme Disease as the control subjects who never had Lyme Disease;⁶⁻⁷ and
34

1 Whereas, Current literature suggests that long-term antibiotic therapy, one of the most common
2 therapies for treating post-Lyme Disease Syndrome, is no better than placebo at treating the
3 symptoms attributed to this condition;^{2,8} and
4

5 Whereas, Extended antibiotic treatment for post-Lyme Disease Syndrome both in experimental
6 studies and in clinical practice settings can cause severe and even fatal adverse effects;^{2, 9-10}
7 and
8

9 Whereas, Many Lyme Disease clinics have opened across the country to provide diagnosis and
10 alternative therapies such to patients who believe that they have post-Lyme Disease
11 Syndrome;¹¹ and
12

13 Whereas, These alternative therapies, which may include high-dose intravenous therapy, Cat's
14 Claw, and urotherapy, can incur significant costs which have been reported as high as \$15,000
15 per month without any proven benefit to their overall condition;¹¹⁻¹⁴ and
16

17 Whereas, Impetuous diagnosis and prescription of treatment for post-Lyme Disease Syndrome
18 can potentially undermine legitimate symptoms and delay diagnosis of serious illnesses;¹⁵ and
19

20 Whereas, The Infectious Diseases Society of America, the Academy of Neurology, and the
21 Academy of Rheumatology are currently working to update the clinical practice guidelines on
22 the treatment of Lyme Disease;¹⁶ therefore be it
23

24 RESOLVED, That our AMA ask appropriate medical societies, in conjunction with the Infectious
25 Diseases Society of America, establish a clear consensus title for this condition as post-Lyme
26 Disease Syndrome, in order to reduce confusion and misunderstanding with the setting in which
27 this phenomenon presents; and be it further
28

29 RESOLVED, That our AMA call on state medical boards to vet alternative treatments for post-
30 Lyme Disease Syndrome utilized by many Lyme Disease clinics and ensure that these clinics
31 do not cause undue harm and do not promise false outcomes, and be it further
32

33 RESOLVED, That our AMA support existing efforts to review the current evidence-based
34 research that investigates the legitimacy of post-Lyme Disease Syndrome and its potential
35 treatments.

Fiscal note: TBD

Date Received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Unconventional Medical Care in the United States H-480.973

Our AMA: (1) encourages the Office of Alternative Medicine of the National Institutes of Health to determine by objective scientific evaluation the efficacy and safety of practices and procedures of unconventional medicine; and encourages its members to become better informed regarding the practices and techniques of such practices; and (2) utilizes the National Institutes of Health's National Center for Complementary and Alternative Medicine's classification system of alternative medicine, "Major Domains of Complementary and Alternative Medicine,; in order to promote future discussion and research about the efficacy, safety, and use of alternative medicine

Alternative Medicine H-480.964

Policy of the AMA on alternative medicine is: (1) Well-designed, controlled research should be done to evaluate the efficacy of alternative therapies. (2) Physicians should routinely inquire about the use of alternative or unconventional therapy by their patients, and educate

themselves and their patients about the state of scientific knowledge with regard to alternative therapy that may be used or contemplated. (3) Patients who choose alternative therapies should be educated as to the hazards that might result from postponing or stopping conventional medical treatment.

Outcomes Research H-450.973

1. It is the policy of the AMA to (a) continue to promote outcomes research as an effective mechanism to improve the quality of medical care, (b) urge that the results of outcomes research be used for educational purposes and not as part of punitive processes, (c) promote the use of outcomes research in the development of practice parameters, (d) advocate that findings of outcomes research which identify individual physicians should only be disclosed within formal peer review processes, and (e) monitor outcomes research activities of the federal government, research organizations, and others.
2. The AMA urges state medical societies, national medical specialty societies, hospital medical staffs, and individual physicians to (a) assist organizations in the planning, development, implementation, and evaluation of appropriate outcomes research, (b) identify the significance and limitations of the findings of outcomes research, and (c) ensure that outcomes research is conducted in a manner that protects the confidentiality of patients and physicians.
3. The AMA urges organizations conducting or planning to conduct outcomes research to (a) ensure the accuracy of the data used in outcomes research, (b) include relevant physician organizations and practicing physicians in all phases of outcomes research, including the planning, development, implementation, and evaluation of outcomes research, (c) provide physician organizations and practicing physicians with adequate opportunity to review and comment on interpretations of the results of outcomes research, and (d) ensure that outcomes research is conducted in a manner that maintains patient and physician confidentiality.

Dietary Supplements and Herbal Remedies H-150.954

1. Our AMA will work with the FDA to educate physicians and the public about FDA's MedWatch program and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.
2. Our AMA continues to urge Congress to modify the Dietary Supplement Health and Education Act to require that (a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy; (b) meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling; (c) meet FDA postmarketing requirements to report adverse events, including drug interactions; and (d) pursue the development and enactment of legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement.
3. Our AMA work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements.
4. Our AMA supports that the product labeling of dietary supplements and herbal remedies: (a) that bear structure/function claims contain the following disclaimer as a minimum requirement: "This product has not been evaluated by the Food and Drug Administration and is not intended to diagnose, mitigate, treat, cure, or prevent disease." This product may have significant adverse side effects and/or interactions with medications and other dietary supplements; therefore it is important that you inform your doctor that you are using this product; (b) should not contain prohibited disease claims.
5. Our AMA supports the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.

6. Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.
7. Our AMA will continue its efforts to educate patients and physicians about the possible ramifications associated with the use of dietary supplements and herbal remedies.

Increasing Awareness of Nootropic Use H-95.935

1. Our AMA: (a) opposes the prescription of controlled substances, including stimulants and wakefulness-promoting agents, for the purpose of cognitive enhancement in otherwise normal, healthy individuals; and (b) discourages the nonmedical use of prescription drugs, including stimulants and wakefulness-promoting agents for cognitive enhancement at all levels of education and in the workplace.
2. Our AMA encourages continued research into the risks and benefits of drugs and other substances for improving function in patients undergoing cognitive decline or who are experiencing cognitive impairment.
3. Our AMA encourages more research into the patterns of use, as well as risks and benefits, of dietary supplements (including herbal remedies) being promoted for cognitive enhancement.
4. Our AMA urges the Federal Trade Commission to examine advertisements for dietary supplements and herbal remedies that claim cognitive enhancement to ensure that they are truthful and not misleading, and are substantiated.

Advertising for Herbal Supplements 440.024MSS

AMA-MSS will and will ask the AMA to: (1) strongly encourage the naming of herbal supplements in a manner so that they cannot be confused with prescription drugs; (2) strongly discourage the advertising of herbal supplements in a way that resembles prescription drug advertisements; (3) work with the appropriate agencies to strengthen regulations regarding the advertising and distribution of herbal supplements and work with appropriate agencies to improve public awareness of regulations and distribution practices associated with herbal supplements, including but not limited to purity, safety, and pregnancy risk.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 32
(A-17)

Introduced by: Vincent Dodson, Aakash Sheth, Neil Borad, Rutgers New Jersey Medical School

Subject: Protecting the Integrity of Phase III Clinical Trials

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Phase III trials are essential for the determination of optimal doses, dose frequencies,
2 administration routes, and endpoints. Phase III trials are by necessity conducted within
3 sufficiently large sample sizes to identify and estimate the occurrence of common adverse
4 reactions;¹ and

5
6 Whereas, Under current FDA guidelines, 9% of phase III suspensions were due to not meeting
7 requirements for safety;² and

8
9 Whereas, Since 1993, even after passing the checkpoint of phase III clinical trials,
10 approximately 1.5 drugs have been withdrawn annually on the basis of safety;¹ and

11
12 Whereas, 62% of 235 recent cancer drug trials did not achieve statistically significant results
13 and there is already very little by way of research to assess the statistical validity of toxicity and
14 the risk to benefit ratio of a therapy for cancer drugs;³ and

15
16 Whereas, Recently passed legislation, H.R.6 (21st Century Cures Act), relaxed requirements of
17 phase III trials for FDA drug approval;⁴ and

18
19 Whereas, One of the ways the 21st Century Cures Act aims to expedite certain phase III clinical
20 trials is to allow the use of biomarkers as a metric for clinical improvement as opposed to using
21 clinical outcomes;⁵ and

22
23 Whereas, Relaxing the criteria for phase III trial length and participant number in favor of
24 biomarkers has led to worse patient outcomes, such as the case of tuberculosis drug,
25 bedaquiline, when an expedited approval process based on the “number of bacteria in sputum”
26 biomarker led to four times as many patient deaths relative to the control group.⁶ Additionally, in
27 the case of VEGF antibody bevacizumab, FDA expedited approval was also granted based on
28 biomarkers but later withdrawn due to lack of evidence demonstrating an overall survival
29 efficacy;⁷ and

30
31 Whereas, There already exist sufficient avenues for the expedited approval of experimental
32 drugs in unique circumstances, such as in the case of the FDA Authorization of emergency use
33 of intravenous antiviral peramivir for 2009 H1N1 Influenza for certain patients as requested by
34 the Centers for Disease Control and Prevention;⁸ and

35
36 Whereas, While reducing phase III trial requirements for approval would facilitate the increased
37 use of experimental drugs by especially sick patients, including the terminally ill⁹, there already
38 exists legislation that accomplishes this; from 2011 to 2015, under the FDA's “compassionate

39 use” exception, the FDA accepted 5,816 of the 5,849 expanded access applications it received
40 for use of experimental drugs by individual patients;¹⁰ therefore be it

41

42 RESOLVED, That our AMA opposes the Food and Drug Administration’s implementation of any
43 new rules, such as those passed in the 21st Century Cures Act, that compromise the robustness
44 and integrity of phase III clinical trials, including but not limited to those rules that allow for the
45 reduction in trial size and length in favor of greater weightage to biomarkers and surrogate
46 markers.

Fiscal note: TBD

Date Received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

FDA H-100.992

Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.

FDA Drug Safety Policies D-100.978

Our AMA will monitor and respond, as appropriate, to the implementation of the drug safety provisions of the Food and Drug Administration Amendments Act of 2007 (FDAAA; P.L. 110-85) so that the Food and Drug Administration can more effectively ensure the safety of drug products for our patients.

Food and Drug Administration H-100.980

(1) AMA policy states that a strong and adequately funded FDA is essential to ensuring that safe and effective medical products are made available to the American public as efficiently as possible. (2) Our AMA: (a) continue to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA; (b) continue to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers and pharmaceuticals, and devices to try to resolve concerns of physicians and to support FDA initiatives of potential benefit to patients and physicians; and (c) continue to affirm its support of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively. (3) Our AMA will continue to monitor and evaluate proposed changes in the FDA and will respond as appropriate.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 33
(A-17)

Introduced by: Farouk Abu Alhana and Parth Patel, University of Toledo College of Medicine; Kate Topalis, UConn School of Medicine; Anish Parekh, Keck School of Medicine; Andrew Ford and Austin Hilt, Northeast Ohio Medical University; Nithya Vijayakumar, University of Michigan Medical School; Gillian Naro, Penn State College of Medicine; Raisa Tikhtman, University of Cincinnati College of Medicine

Subject: AMA Policy on Investing in the Fossil Fuel Industry

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1
2 Whereas, Our AMA has advocated for environmental sustainability through a commitment to
3 “support initiatives to promote environmental sustainability and other efforts to halt global
4 climate change” and “incorporate principles of environmental sustainability within its business
5 operations” (H-135.923); and
6
7 Whereas, The average global temperature has progressively increased since modern
8 recordkeeping began, with 2016 being the warmest year on record;^{1 2} and
9
10 Whereas, approximately 97% of articles published on the topic of climate in the peer-reviewed
11 scientific literature between 1991 – 2011 endorsed the consensus position that humans are
12 causing global warming;³ and
13
14 Whereas, The *Lancet* has characterized climate change as “the biggest global health threat of
15 the 21st century,”⁴ its effects to human health projected to be potentially catastrophic through
16 exacerbations in air pollution, spread of disease vectors, food insecurity and undernutrition,
17 displacement, and mental ill health;⁵ and
18
19 Whereas, Probabilistic analysis indicates that limiting cumulative carbon dioxide emissions from
20 the years 2000 to 2050 to 1,000 gigatons would result in only a 25% probability of exceeding the
21 global warming limit of 2 degrees Celsius targeted by over 100 countries, but this carbon dioxide
22 emission budget would be exhausted by 2027 if recent rates of emissions are maintained, which
23 indicates that urgent action is required to ensure global warming remains below this target;⁶ and
24
25 Whereas, Allowable cumulative carbon dioxide emissions becomes even more restrictive when
26 variables essential to the habitability of Earth other than a warming limit are considered, such as

1 sea level rise, ocean acidification, and biodiversity loss;⁷ and

2

3 Whereas, The carbon potential of the entire pool of proven fossil fuel reserves (2795 gigatons)
4 far exceeds what can be safely burned, constituting nearly five times the carbon budget
5 available through the year 2050, endangering oil and gas companies' reserves as potential
6 stranded assets;⁸ and

7

8 Whereas, 63.04% of all anthropogenic carbon dioxide and methane emissions between 1854 -
9 2010 can be traced to just 90 investor- and state-, and nation-state owned entities whose
10 business is fossil fuel and/or cement production;⁹ and

11

12 Whereas, As a response to this growing crisis, a call for divestment from the fossil fuel industry
13 has emerged that has been embraced by over 700 institutions across the world;^{10 11} and

14

15 Whereas, The international medical community has recently joined this effort, with the British
16 Medical Association (BMA), Canadian Medical Association (CMA), and Royal Australasian
17 College of Physicians, each committing to divest from energy companies whose primary
18 business relies on fossil fuels;^{12 13 14} and

19

20 Whereas, Our AMA acknowledges the health risks associated with climate change and the
21 anthropogenic contributions to its development (H-135.938), yet has not joined its international
22 counterparts in such a divestiture; and

23

24 Whereas, Our AMA recognizes that the voluntary acquisition of financial stock and holdings
25 must not conflict with the Association's values and mission, this notion affirmed by its corporate
26 policies on tobacco (H-500.975); therefore be it

27

28 RESOLVED, That our AMA recognizes the negative effects that greenhouse gas emissions
29 have on human health; and be it further

30

31 RESOLVED, That our AMA urges the federal government to reduce and control the emission of
32 greenhouse gases; and be it further

33

34 RESOLVED, That our AMA consider divestiture of its investments in energy companies whose
35 primary business relies upon fossil fuels; and be it further

36

37 RESOLVED, That our AMA will explore investment opportunities in renewable energy solutions.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Global Climate Change and Human Health H-135.938

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

1

Corporate Policies on Tobacco H-500.975

(1) Our AMA: (a) continues to urge the federal government to reduce and control the use of tobacco and tobacco products; (b) supports developing an appropriate body for coordinating and centralizing the Association's efforts toward a tobacco-free society; and (c) will defend vigorously all attacks by the tobacco industry on the scientific integrity of AMA publications.

(2) It is the policy of our AMA to continue to use appropriate lobbying resources to support programs of anti-tobacco health promotion and advertising.

(3) Our AMA's House of Delegates endorses the April 24, 1996, statement by the AMA Secretary-Treasurer that all physicians, health professionals, medical schools, hospitals, public

health advocates, and citizens interested in the health and welfare of our children should review their personal and institutional investments and divest of any tobacco holdings (including mutual funds that include tobacco holdings); and specifically calls on all life and health insurance companies and HMOs to divest of any tobacco holdings.

(4) Our AMA defines the Tobacco Industry as companies or corporate divisions that directly produce or purchase tobacco for production or market tobacco products, along with their research and lobbying groups, including the Council for Tobacco Research and the Smokeless Tobacco Research Council. A company or corporate division that does not produce or market tobacco products but that has a tobacco producing company as or among its owners will not be considered a prohibited part of the tobacco industry as long as it does not promote or contribute to the promotion, sale and/or use of tobacco products. If such promotional practices begin, the company will be placed on an "unacceptable for support" list.

(5) Accordingly, it is the policy of our AMA (a) not to invest in tobacco stocks or accept financial support from the tobacco industry; (b) to urge medical schools and their parent universities to eliminate their investments in corporations that produce or promote the use of tobacco and discourage them from accepting research funding from the tobacco industry; (c) to likewise urge all scientific publications to decline such funded research for publication; and (d) to encourage state and county medical societies and members to divest of any and all tobacco stocks.

(6) Our AMA (a) encourages state and local medical societies to determine whether candidates for federal, state and local offices accept gifts or contributions of any kind from the tobacco industry, and publicize their findings to both their members and the public; and (b) urges state and county medical societies and local health professionals along with their allies to support efforts to strengthen state and local laws that require public disclosure of direct and indirect expenditures to influence legislation or ordinances, given recent allegations about tobacco industry strategies.

Advocacy for Environmental Sustainability and Climate H-135.923

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.

Green Initiatives and the Health Care Community H-135.939

Our AMA supports: (1) responsible waste management policies, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

Support of Clean Air and Reduction in Power Plant Emissions H-135.949

Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants, substitution of natural gas in lieu of other carbon-based fossil fuels, and continued development of alternative renewable energy sources.

Global Climate Change - The "Greenhouse Effect" H-135.977

Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;(3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity;(4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and (5) encourages humanitarian measures to limit the burgeoning increase in world population.

Clean Air H-135.979

Our AMA supports cooperative efforts with the Administration, Congress, national, state and local medical societies, and other organizations to achieve a comprehensive national policy and program to address the adverse health effects from environmental pollution factors, including air and water pollution, toxic substances, the "greenhouse effect," stratospheric ozone depletion and other contaminants.

Stewardship of the Environment H-135.973

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development

programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Environmental Protection 135.002MSS

AMA-MSS will ask the AMA to support strong federal enforcement of environmental protection regulations. AMA Res 80, A-82 Referred; BOT Rep D, I-82 Adopted; Reaffirmed: MSS COLRP Rep B, I-95; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15

Promotion of Conservation Practices within the AMA 135.005MSS

AMA-MSS will ask the AMA to direct its offices to implement conservation-minded practices whenever feasible. AMA Res 16, A-91 Adopted [G-630.100]; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15

Toward Environmental Responsibility 135.012MSS

(1) AMA-MSS will ask the AMA to (a) recognize the negative impact of climate change on global human health, particularly in the areas of infectious disease, the direct effects of heat, severe storms, food and water availability, and biodiversity; and (b) conduct an internal assessment of its environmental footprint and research creative solutions to minimize it and report back at I-08. (2) AMA-MSS will continue to study climate change and its impact on human health by conducting an analysis of the environmental impact of hospitals, physician practices, and medical industry suppliers and report back at I-08. MSS Amended Rep A, I-07; AMA Res 607, A-08 Referred

Statement of Sustainability Principles 135.013MSS

AMA-MSS will (1) develop a model sustainability statement that medical schools can use as a template for creating institution-specific sustainability mission statements; and (2) encourage all medical schools to adopt mission statements which promote institutional sustainability initiatives such as consumption awareness, waste reduction, energy and water conservation, and the utilization of reusable/recyclable goods. MSS Res 2, A-10; Reaffirmed: MSS Res 10, I-11; Reaffirmed, MSS GC Rep D, I-15

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 34
(A-17)

Introduced by: Trevor Cline, UC Davis School of Medicine; Ryan Denu, University of Wisconsin School of Medicine and Public Health; Kristie Bauman, Temple University; S. Alison Kraemer, Johns Hopkins University School of Medicine; Kevin Stephenoff, University of Toledo; Rachel Ekaireb, UC San Francisco; Jerome Jeevarajan, University of Texas Southwestern Medical School; Charlene Gaw, Mayo Medical School; Dan Pfeifle, University of South Dakota-Sanford School of Medicine; Charlene Gaw, Mayo School of Medicine; Gabby Cahill, University of California San Diego School of Medicine; Anna Yap, Loma Linda University School of Medicine; Brianna Whithorn, Campbell University School of Osteopathic Medicine

Subject: Opposition to Capital Punishment

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Capital punishment has been legally abolished in 105 countries, with more territories
2 and countries outlawing the use of capital punishment each year;¹ and
3
4 Whereas, The US was the only country in the western hemisphere to perform an execution in
5 2016 and performed more executions than every country with the exceptions of China, Iran,
6 Saudi Arabia, Iraq, Pakistan, and Egypt;² and
7
8 Whereas, Capital punishment is permitted by law in 31 states which allow execution by lethal
9 injection, firing squad, hanging, gas chamber, and electrocution;³ and
10
11 Whereas, Capital punishment is permitted by the federal government and United States military
12 even in non-death penalty states, with federal death sentences handed down as recently as
13 2015;⁴ and
14
15 Whereas, 20 executions were performed in the United States in only five states in 2016, only 13
16 states issued death sentences in 2016, and only 2% of counties in the US have accounted for
17 the majority of cases leading to executions since 1976;⁵⁻⁶ and
18
19 Whereas, Recent executions by lethal injection have been reported by witnesses to cause
20 visible suffering and to last for multiple hours;⁷⁻⁹ and
21
22 Whereas, The Supreme Court of the United States has abolished capital punishment for all
23 offenders under the age of 16 in *Thompson v. Oklahoma* (1988), for all juveniles in *Roper v.*
24 *Simmons* (2005), and for all people with an intellectual disability in *Atkins v. Virginia* (2002);¹⁰⁻¹²
25 and
26
27 Whereas, Capital punishment represents less than 0.1% of prison sentences in the United
28 States, but 12% of exonerations are granted to defendants sentenced to death;¹³ and
29

1 Whereas, Execution is irreversible and risks innocent lives, as an estimated 4.1% of criminal
2 defendants sentenced to death are false convictions;¹⁴⁻¹⁵ and
3

4 Whereas, Expert review of available surveys, crime statistics, and associated executions
5 suggests that capital punishment does not effectively deter crime or homicide above and
6 beyond other methods of imprisonment;¹⁶⁻¹⁹ and
7

8 Whereas, Capital punishment is not cost-effective, estimated to cost an additional \$1-2 million
9 per execution compared to noncapital adjudication due to higher jail costs, higher trial costs,
10 higher levels of security, and higher staff-to-inmate ratios;²⁰⁻²³ and
11

12 Whereas, Effective incapacitation can be achieved through mechanisms other than capital
13 punishment, such as life imprisonment;¹⁷ and
14

15 Whereas, Minorities have accounted for a disproportionate number of executions and
16 experience longer appeals processes on death row,²⁴⁻²⁶ therefore be it
17

18 RESOLVED, That the AMA-MSS oppose all forms of capital punishment.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

E-2.06 Capital Punishment

An individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.

In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel. The following actions do not constitute physician participation in execution: (1) testifying as to medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution; (2) certifying death, provided that the condemned has been declared dead by another person; (3) witnessing an execution in a totally nonprofessional capacity; (4) witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonprofessional capacity; and (5) relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution. Physicians should not determine legal competence to be executed. A physician's medical opinion should be merely one aspect of the information taken into account by a legal decision maker such as a judge or hearing officer. When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner for the purpose of restoring competence unless a commutation order is issued before treatment begins. The task of re-evaluating the prisoner should be performed by an independent physician examiner. If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. No physician should be compelled to participate in the process of establishing a prisoner's competence or be involved with treatment of an incompetent, condemned prisoner if such activity is contrary to the physician's personal beliefs. Under those circumstances, physicians should be permitted to transfer care of the prisoner to another physician.

Organ donation by condemned prisoners is permissible only if (1) the decision to donate was made before the prisoner's conviction, (2) the donated tissue is harvested after the prisoner has been pronounced dead and the body removed from the death chamber, and (3) physicians do not provide advice on modifying the method of execution for any individual to facilitate donation. (I) Issued July 1980. Updated June 1994 based on the report "Physician Participation in Capital Punishment," adopted December 1992, (JAMA. 1993; 270: 365-368); updated June 1996 based on the report "Physician Participation in Capital Punishment: Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed," adopted in June 1995; Updated December 1999; and Updated June 2000 based on the report "Defining Physician Participation in State Executions," adopted June 1998.

H-140.896 Moratorium on Capital Punishment

Our AMA: (1) does not take a position on capital punishment; and (2) urges appropriate legislative and legal authorities to continue to implement changes in the system of administration of capital punishment, if used at all, and to promote its fair and impartial administration in accordance with basic requirements of due process.

H-140.898 Medical Profession Opposition to Physician Participation in Execution

Our AMA strongly reaffirms its opposition to physician participation in execution

H-140.950 Physician Participation in Capital Punishment

(1) Physician participation in evaluations of a prisoner's competence to be executed is ethical only when certain safeguards are in place. A physician can render a medical opinion regarding competency which should be merely one aspect of the information taken into account by the ultimate decision maker, a role that legally should be assumed by a judge or hearing officer. Prisoners' rights to due process at the competency hearings should be carefully observed.

(2) When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner to restore competence unless a commutation order is issued before treatment begins.

(3) If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. It will not always be easy to distinguish these situations from treatment for the purpose of restoring the prisoner's competence, and in particular, to determine when treatment initiated to reduce suffering should be stopped. However, there is no alternative at this time other than to rely upon the treating physician to exercise judgment in deciding when and to what extent treatment is necessary to reduce extreme suffering. The cumulative experience of physicians applying these principles over time may lead to future refinements.

Treatment should be provided in a properly-secured, general medical or psychiatric facility, not in a cell block. The task of re-evaluating the prisoner's competence to be executed should be performed by an independent physician examiner.

(4) Given the ethical conflicts involved, no physician, even if employed by the state, should be compelled to participate in the process of establishing a prisoner's competence to be executed if such activity is contrary to the physician's personal beliefs. Similarly, physicians who would prefer not to be involved with treatment of an incompetent, condemned prisoner should be excused or permitted to transfer care of the prisoner to another physician.

370.008MSS Supporting Voluntary Organ Donation from Death Row Prisoners

AMA-MSS will ask the AMA to reexamine the issue of lethal injection and organ retrieval from executed prisoners and report on its findings at A-12. (MSS Res 36, A-11) (AMA Res 3, A-12 Not Adopted)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 35
A-17

Introduced by: Augustus Chang and Periel Shapiro, Rutgers Robert Wood Johnson Medical School, Emaad Siddiqui, Rutgers New Jersey Medical School

Subject: Research, Education and Awareness Regarding Non-Opioid Pain Management Treatments

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1
2 Whereas, In the United States there is an opioid epidemic, with opioid addiction on the rise and
3 overdose related deaths nearly tripling from 1999 to 2014, with 28,647 opioid related deaths in
4 2014 accounting for 60.9% of all drug overdose deaths¹; and
5
6 Whereas, The 2016 CDC Guidelines for Prescribing Opioids for Chronic Pain states that
7 “nonpharmacologic treatments and nonopioid pharmacologic treatments are preferred for
8 chronic pain” and that “extensive evidence suggests some benefits of pharmacologic and
9 nonopioid pharmacologic treatments compared with long term opioid therapy, with less harm”²;
10 and
11
12 Whereas, Decreases in opioid prescriptions can be attributed to increases in usage of non-
13 opioid treatment alternatives. For example, St. Joseph’s Healthcare System Emergency
14 Department in Paterson, NJ implemented the Alternatives to Opioids (ALTO) Program, which
15 utilized evidence-based non-opioid modalities to treat 5 common acute pain conditions. In the
16 first 60 days of the program, 300 patients were treated and 75% of them were treated effectively
17 without opioids.^{3,4,5,6,7,8,9}; and
18
19 Whereas, Specialty organizations such as the American College of Emergency Physicians are
20 working to promote usage of non-opioid and non-pharmacologic pain treatments through
21 education regarding the management of acute and chronic pain without the use of opiates and
22 promoting novel protocols and evidence based approaches to pain management¹⁰; and
23
24 Whereas, Our AMA policy promotes enhanced research, education and clinical practice in the
25 field of pain medicine (AMA Policy D-160.981), and supports timely and appropriate access to
26 non-opioid and non-pharmacologic treatments for pain, including removing barriers to such
27 treatments when they inhibit a patient’s access to care (AMA Policy D-450.956); and
28

- 1 Whereas, Our AMA policy calls the creation of a website directory and the dissemination of
2 available educational and training resources on the use of methadone and other opioid
3 analgesics in clinical practice (AMA Policy 120.985), but lacks explicit policy regarding the
4 dissemination of available educational and training resources for non-opioid and non-
5 pharmacologic analgesics or extensive information on its website regarding such; therefore be it
6
7 RESOLVED That our AMA will encourage enhanced federal funding of research on non-opioid
8 pain management; and be it further
9
10 RESOLVED Our AMA will incorporate into its web site a directory consolidating available
11 information on the safe and effective use of non-opioid analgesics in clinical practice; and be it
12 further
13
14 RESOLVED That our AMA, in collaboration with relevant specialty societies and its Federation
15 partners, will collate and disseminate available educational and training resources on the use of
16 non-opioid treatment modalities.

Fiscal Note: TBD

Date Received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Promotion of Better Pain Care D-160.981

1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic; and (c) will participate in the International Association for the Study of Pain (IASP) International Pain Summit to be held in Montreal, Canada, on September 3, 2010; and encourages the participation of affiliate pain specialty societies, the American Board of Medical Specialties, the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, and other relevant organizations in the IASP Pain Summit.

2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.

3. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines.

4. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality.

Res. 321, A-08 Appended: Res. 522, A-10 Reaffirmed in lieu of Res. 518, A-12 Reaffirmed: BOT Rep. 19, A-16 Reaffirmed in lieu of Res. 117, A-16 Appended: Res. 927, I-16

Pain as the Fifth Vital Sign D-450.956

Our AMA will: (1) work with The Joint Commission to promote evidence-based, functional and effective pain assessment and treatment measures for accreditation standards; (2) strongly support timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient's access to care; (3) advocate that pain as the fifth vital sign be eliminated from professional standards and usage; and (4) advocate for the removal of the pain management component of patient satisfaction surveys as it pertains to payment and quality metrics.

BOT Rep. 19, A-16

Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985

1. Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice.

2. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management.

Sub. Res. 508, A-03 Reaffirmed: CSAPH Rep. 1, A-13 Appended: Res. 515, A-14 Reaffirmed: BOT Rep. 14, A-15

A More Uniform Approach to Assessing and Treating Patients for Controlled Substances for Pain Relief D-120.947

1. Our AMA will consult with relevant Federation partners and consider developing by consensus a set of best practices to help inform the appropriate clinical use of opioid analgesics, including risk assessment and monitoring for substance use disorders, in the management of persistent pain.

2. Our AMA will urge the Centers for Disease Control and Prevention to take the lead in promoting a standard approach to documenting and assessing unintentional poisonings and deaths involving prescription opioids, including obtaining more complete information on other contributing factors in such individuals, in order to develop the most appropriate solutions to prevent these incidents.

3. Our AMA will work diligently with the Centers for Disease Control and Prevention and other regulatory agencies to provide increased leeway in the interpretation of the new guidelines for appropriate prescription of opioid medications in long-term care facilities and in the care of patients with cancer and cancer-related pain, in much the same way as is being done for hospice and palliative care.

BOT Rep. 3, I-13 Appended: Res. 522, A-16 Modified: Res. 918, I-16 Reaffirmed in lieu of: Res. 803, I-16

Pain Management D-120.976

Our AMA will: (1) support more effective promotion and dissemination of educational materials for physicians on prescribing for pain management; (2) take a leadership role in resolving conflicting state and federal agencies' expectations in regard to physician responsibility in pain management; (3) coordinate its initiatives with those state medical associations and national medical specialty societies that already have already established pain management guidelines; and (4) disseminate Council on Science and Public Health Report 5 (A-06), "Neuropathic Pain," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain); and (5) disseminate Council on Science and Public Health Report 5 (A-10), "Maldynia: Pathophysiology and Nonpharmacologic Approaches," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain).

Res. 809, I-04 Appended: CSAPH Rep. 5, A-06 Appended: CSAPH Rep. 5, A-10 Reaffirmed in lieu of Res. 518, A-12

Protection for Physicians Who Prescribe Pain Medication H-120.960

Our AMA supports the following: (1) the position that physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution. It is the policy of the AMA that state medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain before seeking the

implementation of legislation to provide that protection; (2) education of medical students and physicians to recognize addictive disorders in patients, minimize diversion of opioid preparations, and appropriately treat or refer patients with such disorders; and (3) the prevention and treatment of pain disorders through aggressive and appropriate means, including the continued education of doctors in the use of opioid preparations.

(2) Our AMA opposes harassment of physicians by agents of the Drug Enforcement Administration in response to the appropriate prescribing of controlled substances for pain management.

BOT Rep. 1, I-97 Reaffirm: Res. 237, A-99 Appended: Res. 506, A-01 Appended: Sub. Res. 213, A-03 Reaffirmed: CSAPH Rep. 1, A-13, Reaffirmed: BOT Rep. 3, I-13 Reaffirmation A-15

Model Pain Management Program For Medical School Curricula D-295.982

Our AMA will collect, synthesize, and disseminate information about effective educational programs in pain management and palliative care in medical schools and residency programs. Res. 308, A-01 Reaffirmed: CME Rep. 2, A-11 Reaffirmed: CME Rep. 6, A-13

Voluntary Continuing Education for Physicians in Pain Management D-300.996

Our AMA will encourage appropriate organizations to support voluntary continuing education for physicians based on effective guidelines in pain management.

Res. 308, A-01 Modified: CME Rep. 2, A-11 Reaffirmed: CME Rep. 6, A-13

Pain Management Standards and Performance Measures D-295.966

Our AMA, through the Council on Medical Education, shall continue to work with relevant medical specialty organizations to improve education in pain management in medical schools, residency programs, and continuing medical education programs.

CSA Rep. 4, A-02 Reaffirmed: CCB/CLRPD Rep. 4, A-12

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 36
(A-17)

Introduced by: Melissa Dodds, Southern Illinois University, Robert Schnietz, Southern Illinois University School of Medicine

Subject: Insurance Coverage of Skin Care Products in The Treatment of Chronic Skin Disorders

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

-
- 1 Whereas, Atopic dermatitis affects 10-20% of children; ¹ and
2
3 Whereas, Barrier creams and moisturizers are an important therapeutic intervention for the
4 treatment of atopic dermatitis as it is primarily a disease of the skin barrier; ^{2,3,4} and
5
6 Whereas, Liberal application of barrier creams and moisturizers can lower the risk of flaring and
7 thus spare the toxic effects of topical steroids; ⁵ and
8
9 Whereas, A recent study found that the cost associated with the treatment of atopic dermatitis
10 for one child was \$75/month and moisturizing skin products were the largest contributor to that
11 cost; ⁶ and
12
13 Whereas, Topical barrier creams and moisturizers play a role in the treatment atopic dermatitis
14 as well as irritant hand dermatitis, ichthyosis vulgaris, other congenital forms of ichthyosis, and
15 epidermolysis bullosa among others^{7,8}; and
16
17 Whereas, Patients with congenital ichthyosis spend an average of \$608 per year on over-the-
18 counter (OTC) moisturizers and keratolytics; ⁹ and
19
20 Whereas, The use of OTC medicine is estimated to save the system \$102 billion a year, in part
21 through a decreased need for office visits and diagnostic tests, according to a 2012 study
22 commissioned by the Consumer Healthcare Products Association; ¹⁰ and
23
24 Whereas, The cost of treating a chronic disease in which treatment is reliant on OTC products
25 places low-income patients at risk for suboptimal treatment and may result in overall increased
26 costs to the system due to increased doctor visits and necessity for prescription drugs due to
27 disease flares; ⁹ and
28
29 Whereas, Many major insurers cover a number of over-the-counter drugs and healthcare
30 associated products; for example aspirin is covered by all major insurers when prescribed for
31 cardiovascular disease prevention and over-the-counter birth control items, like condoms,
32 spermicides, and Plan B pill among others are covered by many major insurers; ¹¹ and
33
34 Whereas, Existing AMA policy encourages health insurers and health plans to cover medically
35 necessary drugs for which no prescription alternatives exist (H185.956); and
36

1 Whereas, A study found an OTC petroleum-based skin protectant moisturizer (aquaphor healing
2 ointment) to be of equal efficacy and at least 47 times more cost effective when compared to
3 two of the prescription barrier repair creams, Atopiclair and EpiCeram;¹² therefore be it
4
5 RESOLVED, That our AMA-MSS supports insurance coverage of over-the-counter skin care
6 products used in the treatment of chronic skin disorder

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Health Plan Coverage for Over-the-Counter Drugs H-185.956

Our AMA: (1) opposes mandated health plan coverage for over-the-counter (OTC) pharmaceuticals, including those that had previously been available only with a prescription; (2) encourages health insurers and health plans to cover medically necessary OTC drugs for which no prescription alternative exists; and (3) continues to support efforts to study the effects of

converting medically necessary drugs from prescription to over-the-counter status on the costs and access to such medications.

Opposition to FDA's Rx to OTC Paradigm Shift H-120.938

Our AMA will: (1) submit comments during the public comment period expressing our concerns with the Food and Drug Administration's (FDA's) proposed paradigm shift; (2) continue to monitor FDA's action on this issue; (3) encourage the FDA to study the cost implications switching prescription drugs to over-the-counter status will have on patient out of pocket costs; and (4) strongly encourage the FDA to initiate a formal public comment process before reclassifying any prescription drug to over-the-counter status.

Cost of Prescription Drugs H-110.997

Our AMA: (1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;

(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;

(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;

(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and

(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 37
(A-17)

Introduced by: Rishi Thaker, Touro College of Osteopathic Medicine- Middletown, NY; Jad Dandashi, Texas A&M Health Science Center College of Medicine; Usman Aslam and Ali Bokhari, NYIT College of Osteopathic Medicine; Andrew Ding, Frank H. Netter MD School of Medicine at Quinnipiac University; Sohayla Rostami, Rocky Vista University College of Osteopathic Medicine; Ludwig Koenenke, Thomas Jefferson University- Sidney Kimmel Medicine College

Subject: Recognizing Poverty-level Wages as a Social Determinant of Health

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1
2 Whereas, Low socioeconomic status is associated with an earlier death by an average of 2.3
3 years, making it a more dangerous risk factor for early mortality than high blood pressure or
4 obesity;¹
5
6 Whereas, Women from low socioeconomic status suffer higher rates of infant mortality and low
7 birth weight;²
8
9 Whereas, Low socioeconomic status is associated with higher rates of diabetes, hypertension,
10 osteoarthritis and other chronic disease, and experience greater morbidity and mortality risk in
11 the management of these diseases;^{3, 4}
12
13 Whereas, Individuals with poverty-level wages make poorer nutritional and health care choices,
14 including special populations like pregnant women;^{4, 5, 6}
15
16 Whereas, At full-time employment the current minimum wage produces a poverty-level wage,
17 and a single parent with two children must work over 50 hours per week at minimum wage to
18 stay above the poverty line;^{7, 8}
19
20 Whereas, Higher incomes provide means for purchasing health insurance, better nutrition,
21 housing, and schooling.^{9, 10}
22
23 Whereas, Increasing the minimum wage reduces the population of individuals living below the
24 poverty line, with each 10% increase in the minimum wage reducing poverty by 2.4%;^{11, 12, 13}
25

1 Whereas, Statistical models using historical data demonstrated a one dollar increase in the
2 federal minimum wage could be associated with a 1-2% decrease in low birthweight and a 4%
3 decrease in neonatal mortality, nationwide; ¹⁴
4

5 Whereas, The minimum wage is intended to reduce poverty by encouraging work, increasing
6 economic purchasing power and reducing exploitation of working families; ^{16, 17}
7

8 Whereas, The federal minimum wage has not been increased since 2009, the third longest
9 period of time since the Fair Labor Standards Act was enacted in 1938; ^{11, 18}
10

11 Whereas, The federal minimum wage has lost 10% of it's purchasing power due to inflation
12 since 2009; ¹¹
13

14 Whereas, Raising the minimum wage would increase the incomes of over 35 million individuals,
15 or 25% of all workers, including low- and mid-skill workers, through the "wage floor effect"; ⁷
16

17 Whereas, Contrary to common belief, modern state, federal and international economic
18 evidence demonstrates that raising the minimum wage actually improves business efficiency,
19 drives economic growth, and may even increase employment; ^{11, 19, 20}
20

21 Whereas, Policies intended to increase income from poverty-level wages have generate a
22 positive impact on health outcomes. ¹⁰
23

24 Whereas, Moving from poverty-level wages towards living wages improves insurance
25 affordability and access; ^{9, 21}
26

27 Whereas, Poverty-level wages cost the US Federal Government \$158.2 billion dollars a year in
28 extra public assistance for working families; ¹⁵
29

30 Whereas, Current AMA and AMA-MSS policy neglects to address the effect of poverty-level
31 wages on insurance affordability or healthcare outcomes;
32

33 RESOLVED, that our AMA-MSS declare poverty-level minimum wages a negative social
34 determinant of health; and be it further
35

36 RESOLVED, that our AMA-MSS supports increasing the minimum wage above poverty-level
37 wages, including through the implementation of wage floor mechanisms that automatically
38 account for the impact of inflation.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:
Poverty Screening as a Clinical Tool for Improving Health Outcomes H-160.909
Our AMA encourages screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources.
Poverty Screening as a Clinical Tool for Improving Health Outcomes 160.025MSS
AMA-MSS will ask the AMA to (1) support the development of standardized, validated questionnaires to screen for social and economic risk factors with high sensitivity and specificity; and (2) encourage the use of questionnaires to screen for social and economic risk factors in order to improve care plans, and direct patients to appropriate resources. (MSS Res 20, I-12) (Amended AMA Res 404, A-13 Adopted [H-160.909])
Medical Care for Patients with Low Incomes H-165.855
It is the policy of our AMA that:
(1) states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or with premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations. (2) in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans. (3) to support the development of a safety net mechanism, allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. (4) tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area through auto-enrollment until the next enrollment opportunity. Patients who have been auto-enrolled should be permitted to change plans any time within 90 days of their original enrollment. (5) state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available under Medicaid, but are not medical benefits per se. (6) as the nonelderly and nondisabled populations transition into needing chronic care, they should be

eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage. (7) our AMA encourages the development of pilot projects or state demonstrations, including for children, incorporating the above recommendations. (Modify Current HOD Policy) (8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects.

Eliminating Health Care Disparities for Children with Special Health Care Needs:

The MSS formally establishes support for the following HOD policies:

H-165.855 Medical Care for Patients with Low Incomes [see above]

Support for Public Health D-440.997

1. Our AMA House of Delegates request the Board of Trustees to include in their long range plans, goals, and strategic objectives to support the future of public health in order "to fulfill society's interest in assuring the conditions in which people can be healthy." This shall be accomplished by AMA representation of the needs of its members? patients in public health-related areas, the promotion of the necessary funding and promulgation of appropriate legislation which will bring this to pass.

2. Our AMA: (A) will work with Congress and the Administration to prevent further cuts in the funds dedicated under the Patient Protection and Affordable Care Act to preserve state and local public health functions and activities to prevent disease; (B) recognizes a crisis of inadequate public health funding, most intense at the local and state health jurisdiction levels, and encourage all medical societies to work toward restoration of adequate local and state public health functions and resources; and (C) in concert with state and local medical societies, will continue to support the work of the Centers for Disease Control and Prevention, and the efforts of state and local health departments working to improve community health status, lower the risk of disease and protect the nation against epidemics and other catastrophes.

3. Our AMA recognizes the importance of timely research and open discourse in combatting public health crises and opposes efforts to restrict funding or suppress the findings of biomedical and public health research for political purposes.

State Options to Improve Coverage for the Poor D-165.957

Our AMA (1) urges national medical specialty societies, state medical associations, and county medical societies to become actively involved in and support state-based demonstration projects to expand health insurance coverage to low-income persons; and (2) encourages state governments to maintain an inventory of private health plans and design an easily accessible, consumer-friendly information clearinghouse for individuals, families, and small businesses on available plans for expanding health insurance coverage.

Giving States New Options to Improve Coverage for the Poor D-165.966

Our AMA will (1) advocate that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes, including combining refundable, advanceable tax credits inversely related to income to purchase health insurance coverage with converting Medicaid from a categorical eligibility program to one that allows for coverage of additional low-income persons based solely on financial need; (2) advocate for changes in federal rules and federal financing to support the ability of states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds; and (3) continue to work with interested state medical associations, national medical specialty societies, and other relevant organizations to further develop such state-based options for improving health insurance coverage for low-income persons.

Strategies to Address Rising Health Care Costs H-155.960

Our AMA:

(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government; (2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease; (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and (d) promote "value-based decision-making" at all levels; (3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training; (4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers; (5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors; (6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings; (7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and (8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care. (9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 38
(A-17)

Introduced by: Rugaya Abaza, David Carney, Mark Giorgi, Parnia Salehi, Morehouse School of Medicine

Subject: Preventing Resident Physician Suicide

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

- 1 Whereas, Physicians' suicide rates are higher than those of the general population and
2 depression among physicians in training is less studied;¹ and
3
4 Whereas, Suicide is the 2nd most common cause of death among medical students following
5 accidents;¹ and
6
7 Whereas, Around 28% of residents experience a major depressive episode during training
8 versus 8 percent of similarly aged individuals in the U.S. general population;² and
9
10 Whereas, The suicide rate among male physicians is 1.41 times greater than the general
11 population and the rate among female physicians is 2.27 times greater than the general
12 population;³ and
13
14 Whereas, A randomized trial of interns found at least one incidence of suicidal ideation rates as
15 high as 21.2% over the course of the year;⁴ and
16
17 Whereas, Physicians who committed suicide were less likely to be receiving mental health
18 treatment compared to non-physicians who committed suicide, even though depression was
19 found to be a significant risk factor at approximately the same rate in both groups;⁵ and
20
21 Whereas, Analysis of suicide victims found that physicians were more likely than non-physicians
22 to have barbiturates and benzodiazepines present on toxicology but were less likely to have
23 antidepressants on toxicology;⁵ and
24
25 Whereas, 42% of physicians will meet the criteria of Major Depressive Disorder (MDD) in their
26 first year of residency;⁶ and
27
28 Whereas, During the physician's intern year, burnout rates increased from 4.3% at the
29 beginning of the year to 55.3% at the end of the year with symptoms including "emotional
30 exhaustion, depersonalization, and a sense of decreased personal accomplishment";⁷ and
31
32 Whereas, Residents who appropriately sought treatment for mental health issues were better
33 able to take care of their patients and proved to be more resilient during stressful situations;⁸
34 and
35
36 Whereas, Recent graduates from US residencies have recognized a lack of adequate education
37 and training on the topic of physician depression and suicide;⁷ and

1 Whereas, Rates of resident physician burnout range from 60% to 76% and are steadily
2 increasing along with the rates of depression in these same physicians;⁹ and

3
4 Whereas, There is a significant correlation between depression in resident physicians and long
5 work hours;⁶ and

6
7 Whereas, Sleep-deprived residents are at a higher risk of depression and burnout;¹⁰ and

8
9 Whereas, Sleep-deprivation in cardiothoracic surgeons led to an 85% increase in errors when
10 reading electrocardiograms;¹¹ and

11
12 Whereas, Schedules built on a 24 hour shift foundation were found to increase risk of
13 occupational hazards and medical errors including needle sticks, diagnostic errors, and other
14 attention related errors during their shift, as well as having a negative impact on the mental
15 health of the resident physicians;¹² and

16
17 Whereas, 84% of interns are non-compliant with mandated work hour regulations;¹² and

18
19 Whereas, Physicians that had a high score on the exhaustion factor on the Beck's
20 Hopelessness Scale had a higher score of hopelessness, a recognized psychometric marker of
21 suicide risk;¹³ and

22
23 Whereas, In March of 2017 the previous cap placed on resident work hours that limited an
24 intern resident's shift hours to 16 was removed in favor of a 24 hour cap;¹⁴ and

25
26 Whereas, 87.5% of depressed physicians also suffer from burnout symptoms;¹⁵ and

27
28 Whereas, "Spending too many hours at work" was one of the top four reasons identified by
29 physicians in 2017 that influenced their feelings of being burnt out along with "too many
30 bureaucratic tasks", "feeling like just a cog in a wheel", and "increased computerization of
31 practice";¹⁶ and

32
33 Whereas, Male doctors committed suicide at a rate 70% higher than other professionals; among
34 female doctors, that rate ranged from 250% to 400% higher;¹⁷ and

35
36 Whereas, Stress amongst residents is common and likely due to residents and physicians
37 feeling unappreciated and having a poor work-life balance;⁹ and

38
39
40 Whereas, Fear of stigmatization by colleagues may influence a physician's decision to seek
41 support for their concerns about their mental health;¹⁸ and

42
43 Whereas, Previously implemented mental health resources for physicians including designated
44 spaces referred to as "reset rooms", environmental changes including the addition of art into
45 physician spaces, and schedule changes were found to be efficacious in improving physician
46 wellbeing, raising provider satisfaction in the departments by 18% and decreasing burnout by
47 22% in one year;¹⁹ and

48
49 Whereas, Mindfulness exercises and meditation have been found to decrease stress and
50 burnout in physicians;²⁰ therefore be it

51
52 RESOLVED, That our AMA-MSS encourage residency programs to provide mental health

1 support and therapy for residents by those specifically trained to treat healthcare providers in
2 order to help them deal with the increased stress and heavy workload; and be it further

3
4 RESOLVED, That our AMA-MSS urge residency programs to include consideration of resident
5 mental health and average daily workload in deciding work hours for residents, particularly in
6 those programs implementing 24 hour shifts; and be it further

7
8 RESOLVED, That our AMA-MSS encourage hospitals to create mental health resources such
9 as “reset rooms” or other such dedicated spaces, incorporation of art in the physician
10 workspaces, meditation, confidential resident support groups, and other similar resources
11 available for residents in order to create an environment that is supportive and more
12 comfortable to reduce burnout; and be it further

13
14 RESOLVED, That our AMA-MSS encourage hospitals to identify factors in their own programs
15 that might negatively impact resident mental health and to address those identified factors to the
16 best of their abilities.

Fiscal note: TBD

Date received: 04/20/2017

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Placing a priority on mental health enables physicians to better take care of themselves and their patients. *American foundation for Suicide Prevention*.
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RELEVANT AMA AND AMA-MSS POLICY:

Increasing Detection of Mental Illness and Encouraging Education D-345.994

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.
 2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.
- Res 412, A-06; Appended: Res 907, I-12

Access to Confidential Health Services for Medical Students and Physicians H-295.858:

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
 - A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
 - B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;

Physician and Medical Student Burnout D-310.968

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a

reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.

2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.

3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.

4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.

5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

Improving Physician Mental Health and Reducing Stigma through Revision of Medical Licensure Applications 345.007MSS

AMA-MSS aims to reduce stigmatization mental health issues in the medical community by (a) opposing state medical boards' practice of issuing licensing applications that equate seeking help for mental health issues with the existence of problems sufficient to create professional impairment and (b) opposing the breach in a physician's private health record confidentiality by requiring access to these records when an applicant reports treatment. MSS Res 17, I-13

Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools 345.009MSS

AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. MSS Res 15, I-15

Mindfulness Education to Address Medical Student Stress and Burnout 295.160MSS:

AMA-MSS will ask the AMA to (1) amend D-310.968 by insertion and deletion as follows: D-310.968: Intern, and Resident, and Medical Student Burnout: 1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students. 2. Our AMA will work with other interested groups to regularly inform the appropriate Graduate Medical Education designated institutional officials, program directors, resident physicians, and attending faculty about resident/fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through the appropriate media outlets. such media as the AMA's GME e-Letter. 3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students. 4. Our AMA will encourage further studies and disseminate the results of studies on physician burnout to the medical education and physician community. 5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements, with a report back at the 2009 Interim Meeting of the AMA House of Delegates; and (2) encourage the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout. (MSS Res 8, A-11) (AMA Res 919, I-11 Adopted as Amended [D-310.968])

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 39
(A-17)

Introduced by: Sheridan Markatos and Kathleen Duemling, Central Michigan University
College of Medicine; Jamilah Alhashidi, Oakland University William
Beaumont School of Medicine

Subject: Impact of Detracting Patient Autonomy in Eating Disorder Treatment

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

-
- 1 Whereas, The prevalence of eating disorders (ED) in the United States is estimated at 30 million
2 or higher, and “every 62 minutes at least one person dies as a direct result from an eating
3 disorder”;^{1,2} and
4
- 5 Whereas, “EDs have the highest mortality rate of any mental illness”; however, only 10% of
6 patients receive treatment;³ and
7
- 8 Whereas, Studies have found no correlation between BMI and a patient seeking treatment,
9 meaning the common belief that patients will seek treatment once the ED has progressed to a
10 life-threatening degree is erroneous;⁴ and
11
- 12 Whereas, Individuals over the age of 18 have the right to refuse treatment unless the parents
13 first receive guardianship and/or conservatorship from a court order, even if the child is under
14 parental healthcare coverage;⁵ and
15
- 16 Whereas, Court orders can delay a patient’s treatment, and the earlier a patient receives
17 treatment for an ED, the greater the likelihood of recovery;⁶ and
18
- 19 Whereas, Research has shown that eating disorders may alter an individual’s sense of identity
20 and values, thus impairing the ability of an ED patient to make healthcare decisions, even in the
21 setting of retained intellectual capacity;⁷ and
22
- 23 Whereas, One study demonstrated that diminished mental capacity occurs in one-third of
24 patients with severe anorexia nervosa, is associated with a low BMI, and results in inability to
25 appraise their condition, and therefore less desire for treatment;⁸ and
26
- 27 Whereas, The body image distortion that characterizes EDs and the impairment of judgment
28 and cognition due to the physiologic effects of malnutrition frequently results in patients refusing
29 treatment;⁶ and
30
- 31 Whereas, Research has shown that involuntarily admitted patients retrospectively agreed they
32 needed treatment, and furthermore, those patients demonstrated a more positive mindset
33 toward the treatment they received;⁹ and
34
- 35 Whereas, A study done at The ACUTE Center for Eating Disorders at Denver Health, the only
36 inpatient eating disorder treatment facility in the United States, concluded that patients with

1 anorexia nervosa who are deemed to be the most medically ill often require involuntary
2 treatment;⁶ and
3

4 Whereas, Compulsory treatment is accepted when necessary in psychotic disorders; however,
5 controversy still surrounds this issue in anorexia nervosa and other EDs;¹⁰ and
6

7 Whereas, Those arguing against compulsory treatment of EDs emphasize patient autonomy
8 and classify EDs as a sociocultural phenomenon;¹⁰ and
9

10 Whereas, Specialists argue that eating disorders are a serious illness and not a conscious
11 choice;¹¹ and
12

13 Whereas, Patient autonomy includes the ability of the patient to make decisions him or herself
14 regarding treatment, despite the physician believing that a choice may be potentially wrong or
15 harmful;⁹ and
16

17 Whereas, Autonomous decisions are contingent upon one's ability to use rational deliberation
18 and whether or not one is competent to make a particular choice within the time and setting;⁹
19 and
20

21 Whereas, In general, psychiatrists and eating disorder specialists tend to support compulsory
22 treatment in order to protect patients, independent of views about their decision-making
23 capacity;^{12,13} therefore be it
24

25 RESOLVED, That our AMA study the outcome of detracting a patient's autonomy in favor of
26 involuntary treatment in the setting of life-threatening eating disorders.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Eating Disorders H-150.965

The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as is obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for interventional counseling; and (4) participates in this effort by consulting with appropriate specialty societies and by assisting in the dissemination of appropriate educational and counseling materials pertaining to unhealthy eating, dieting, and weight restrictive behaviors.

Res 417, A-92; Appended: Res 503, A-98

Eating Disorders and Promotion of Healthy Body Image D-150.984

1. Council on Science and Public Health Report 8-A-07, Eating Disorders and Promotion of Healthy Body Image, will be widely disseminated to assist primary care physicians and other healthcare professionals in the early recognition and treatment of eating disorders.
2. Our AMA supports increased funding for research on the epidemiology, etiology, diagnosis, prevention, and treatment of eating disorders, including research on the effectiveness of school-based primary prevention programs for pre-adolescent children and their parents, in order to prevent the onset of eating disorders and other behaviors associated with a negative body image

CSAPH Rep. 8, A-07

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 40
(A-17)

Introduced by: Henry Greyner-Almeida, Moudi Hubeishy, Anisha Chava, Natasha Borrero, Kelly Coughlin, Nikhita Chahal, Emily Benton, Mattie Rosi-Schumacher, Timothy Shub, Jacobs School of Medicine and Biomedical Sciences at the State University of New York at Buffalo.

Subject: Addressing Burnout in Medical Education Faculty

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Burnout has been defined by a validated instrument, the Maslach Burnout Inventory,
2 as “emotional exhaustion, depersonalization, and reduced personal accomplishment;”¹ and
3
4 Whereas, Medical students, residents/fellows, and physicians are more likely to develop burnout
5 than the general population, affecting professionalism, patient-physician relationships, patient
6 mortality, and medical errors;²⁻⁷ and
7
8 Whereas, Burnout, as defined by the Maslach Burnout Inventory, was prevalent in the
9 healthcare research faculty of one institution in a study prompted by the relative lack of data on
10 burnout in the faculty of medical schools, and the researchers involved concluded that the
11 alleviation of burnout in these faculty members might be beneficial for their ongoing
12 performance;⁸ and
13
14 Whereas, Out of 2,386 faculty from 26 US medical schools surveyed, 21% stated that they
15 would leave academic medicine due to dissatisfaction. Predictors of dissatisfaction include
16 unrelatedness, distress, lack of engagement, and lack of institutional support, which are
17 variables that parallel the definition of burnout, and furthermore, the relation between burnout
18 and job dissatisfaction have been documented;^{9,10} and
19
20 Whereas, A quarter of faculty participants in a national survey of medical faculty reported sub-
21 optimal ‘vitality’ - defined as “professional fulfillment, motivation, and commitment to ongoing
22 intellectual and personal growth, full professional engagement, enthusiasm, positive feelings of
23 aliveness and energy, and excitement about work;”¹¹ and
24
25 Whereas, Perceived satisfaction among medical faculty and mentors has important influence on
26 medical students, such as in selection of medical specialties;¹²⁻¹⁴ and
27 Whereas, The verified questionnaire, TUMS Stage of Change and Maslach Burnout Inventory,
28 has been used to demonstrate a significant relationship between clinical faculty of medical

1 schools willingness to change and burnout suggesting that faculty members who are found to
2 have significant burnout are less likely to implement change;¹⁵ and
3 Whereas, The AMA's Practice Improvement Strategies initiative has invested resources into the
4 creation of a web based module education system with specific modules targeting prevention of
5 physician burnout;¹⁶ and

6
7 Whereas, Existing AMA policies and AMA-MSS policies aim to address variables described
8 within the definition of burnout among medical students and physicians but none address the
9 variables of burnout among medical school pre-clinical and clinical faculty; and

10
11 Whereas, The Liaison Committee for Medical Accreditation (LCME, 1942) is co-sponsored by
12 the American Medical Association (AMA, 1846) and the Association of American Medical
13 Colleges (AAMC, 1876) through a memorandum of understanding (MOU) between the
14 respective groups, which includes the appointment of a LCME co-secretary who may act
15 towards addressing nationwide concerns within medical schools;^{17,18} therefore be it

16
17 RESOLVED, That the AMA encourage the immediate formation of task forces within medical
18 schools that aim to appropriately and collaboratively evaluate the burnout of their pre-clinical
19 and clinical faculty members through the use of a validated instrument; and be it further

20
21 RESOLVED, That the AMA-MSS strongly encourage the Association of American Medical
22 Colleges and the Liaison Committee on Medical Education to conduct research into how
23 burnout in pre-clinical and clinical medical school faculty relates to professionalism; and be it
24 further

25
26 RESOLVED, That the AMA-MSS strongly encourage the Association of American Medical
27 Colleges and the Liaison Committee on Medical Education to investigate the link between how
28 medical school pre-clinical and clinical faculty burnout affects medical student: performance,
29 professionalism, burnout, and career choice.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Improving Mental Health Services for Undergraduate and Graduate Students H-345.970

Our AMA supports: (1) strategies that emphasize de-stigmatization and enable timely and affordable access to mental health services for undergraduate and graduate students, in order to improve the provision of care and increase its use by those in need; (2) colleges and universities in emphasizing to undergraduate and graduate students and parents the importance, availability, and efficacy of mental health resources; and (3) collaborations of university mental health specialists and local public or private practices and/or health centers in order to provide a larger pool of resources, such that any student is able to access care in a timely and affordable manner.

Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians H-345.973

Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place.

Access to Confidential Health Services for Medical Students and Physicians H-295.858

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

- A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
- B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
- C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
- D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven"• non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.

3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:

A. be available to all medical students on an opt-• out basis;

B. ensure anonymity, confidentiality, and protection from administrative action;

C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and

D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.

Results suggest addressing burnout may be an opportunity for research administrators to improve performance, job satisfaction, and retention.

Medical Student Support Groups H-295.999:

1. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty.

2. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

Physician and Medical Student Burnout D-310.968

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.

2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.

3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.

4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.

5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

Expansion of Student Health Services H-295.872:

1. It is AMA policy that medical students should have timely access to needed preventive and therapeutic medical and mental health services at sites in reasonable proximity to where their education is occurring.

2. Our AMA will encourage the Liaison Committee on Medical Education to develop an annotation to its standard on medical student access to preventive and therapeutic health services that includes a specification of the following:

- a. Medical students should have timely access to needed preventive and therapeutic medical and mental health services at sites in reasonable proximity to where their education is occurring.
- b. Medical students should have information about where and how to access health services at all locations where training occurs.
- c. Medical schools should have policies that permit students to be excused from class or clinical activities to seek needed care.

Stigmatization of Mental Health Disorders within the Medical Profession 345.004MSS:

AMA-MSS will ask the AMA to address the stigmatization of mental health disorders in medical professionals by medical professionals by taking an active role in activities such as developing and/or encouraging programming to promote awareness about and reduce this stigmatization.(MSS Res 37, A-11)(Modified: MSS GC Report A, I-16)

Improving Physician Mental Health and Reducing Stigma through Revision of Medical Licensure Applications 345.007MSS

AMA-MSS aims to reduce stigmatization mental health issues in the medical community by (a) opposing state medical boards' practice of issuing licensing applications that equate seeking help for mental health issues with the existence of problems sufficient to create professional impairment and (b) opposing the breach in a physician's private health record confidentiality by requiring access to these records when an applicant reports treatment. MSS Res 17, I-13

Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools 345.009MSS

AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4)

educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. (MSS Res 15, I-15)

Addressing Medical Student Mental Health Through Data Collection and Screening

345.012MSS:

AMA-MSS will ask that our AMA (1) encourage study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; and (2) encourage medical

schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students.(MSS Res 14, I-16)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 41
(A-17)

Introduced by: University of Connecticut School of Medicine

Subject: Addressing Social Media Usage and its Negative Impacts on Mental Health

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

- 1 Whereas, 71% of American teenagers use Facebook, 52% use Instagram, 41% use Snapchat,
2 24% of teens “go online almost constantly”, and 92% go online every day;¹ and
3
4 Whereas, 68% of all US adults use Facebook, with 76% of them saying they check it daily;² and
5
6 Whereas, There is evidence that individuals with increased social media site visits per week had
7 significantly increased odds of depression;³ and
8
9 Whereas, There are positive and significant correlations between symptoms of anxiety and
10 depression and addictive use of social media;⁴ and
11
12 Whereas, The use of Facebook is negatively associated with well-being;^{5,6} and
13
14 Whereas, There is evidence that increased use of social media is linked with higher levels of
15 anxiety and depression in adolescents;⁷ and
16
17 Whereas, Research has found that use of multiple social media platforms is independently
18 associated with symptoms of depression and anxiety;⁸ and
19
20 Whereas, There is evidence that spending more time on Facebook and/or viewing Facebook
21 more frequently, provides people with the opportunity to spontaneously engage in Facebook
22 social comparisons, which in turn, is associated with greater depressive symptoms;⁹ and
23
24 Whereas, The American Psychological Association has found that 48% of millennials (ages 18-
25 37 years old), 37% of Gen Xers (ages 38-51 years old), and 22% of baby boomers (52-70 years
26 old) worry about the negative effects of social media on their physical and mental health;¹⁰ and
27
28 Whereas, The American Academy of Pediatrics recognizes depression that develops when
29 preteens and teens spend a great deal of time on social media sites, and advises parents to talk
30 to their children and adolescents about their online use;¹¹ and
31
32 Whereas, there are school-based mental health programs that have evidence of positive impact
33 across a range of emotional and behavioral problems, there are no programs that address the
34 association between social media usage and negative mental health sequelae;^{12,13} and
35
36 Whereas, Current AMA policy encourages “physicians to continue efforts to raise
37 parent/guardian awareness about the importance of educating their children about safe internet
38 and social media use,” it does not address the association between social media usage and

1 increased depression, increased anxiety, and decline in subjective well-being in children,
2 adolescents, and adults; (H-60.934) and
3

4 Whereas, Current AMA policy that addresses online bullying does not address the association
5 between social media usage and increased depression, increased anxiety, and decline in
6 subjective well-being in children, adolescents, and adults; (H-515.959) and therefore be it
7

8 RESOLVED, that our AMA collaborate with relevant professional organizations to (a) develop
9 continuing education programs to enhance physicians' knowledge of the health impacts of
10 social media usage, and (b) to develop effective clinical tools and protocols for the identification,
11 treatment, and referral of children, adolescents, and adults at risk for and experiencing mental
12 health sequelae of social media usage; and be it further
13

14 RESOLVED, that our AMA advocate for schools to provide safe and effective educational
15 programs by which students can learn to identify and mitigate the onset of mental health
16 sequelae of social media usage.

Fiscal note: TBD

Date received: 04/20/2017

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adolescents: a meta-analytic review. *Am. J. Community Psychol.* **25**, 115–52 (1997).

RELEVANT AMA AND AMA-MSS POLICY:

Reduction of Online Bullying H-515.959

Our AMA urges social networking platforms to adopt Terms of Service that define and prohibit electronic aggression, which may include any type of harassment or bullying, including but not limited to that occurring through e-mail, chat room, instant messaging, website (including blogs) or text messaging.

Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934

Our AMA:

- (1) Recognizes the positive role of the Internet in providing health information to children and youth.
- (2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
- (3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.
- (4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.
- (5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.

Bullying Behaviors Among Children and Adolescents H-60.943

Our AMA: (1) recognizes bullying as a complex and abusive behavior with potentially serious social and mental health consequences for children and adolescents. Bullying is defined as a pattern of repeated aggression; with deliberate intent to harm or disturb a victim despite apparent victim distress; and a real or perceived imbalance of power (e.g., due to age, strength, size), with the more powerful child or group attacking a physically or psychologically vulnerable victim;

(2) advocates for federal support of research: (a) for the development and effectiveness testing of programs to prevent or reduce bullying behaviors, which should include rigorous program evaluation to determine long-term outcomes; (b) for the development of effective clinical tools and protocols for the identification, treatment, and referral of children and adolescents at risk for and traumatized by bullying; (c) to further elucidate biological, familial, and environmental underpinnings of aggressive and violent behaviors and the effects of such behaviors; and (d) to study the development of social and emotional competency and resiliency, and other factors that mitigate against violence and aggression in children and adolescents;

(3) urges physicians to (a) be vigilant for signs and symptoms of bullying and other psychosocial trauma and distress in children and adolescents; (b) enhance their awareness of the social and mental health consequences of bullying and other aggressive behaviors; (c) screen for psychiatric comorbidities in at-risk patients; (d) counsel affected patients and their families on effective intervention programs and coping strategies; and (e) advocate for family, school, and community programs and services for victims and perpetrators of bullying and other forms of violence and aggression;

(4) advocates for federal, state, and local resources to increase the capacity of schools to provide safe and effective educational programs by which students can learn to reduce and

prevent violence. This includes: (a) programs to teach, as early as possible, respect and tolerance, sensitivity to diversity, and interpersonal problem-solving; (b) violence reduction curricula as part of education and training for teachers, administrators, school staff, and students; (c) age and developmentally appropriate educational materials about the effects of violence and aggression; (d) proactive steps and policies to eliminate bullying and other aggressive behaviors; and (e) parental involvement;

(5) advocates for expanded funding of comprehensive school-based programs to provide assessment, consultation, and intervention services for bullies and victimized students, as well as provide assistance to school staff, parents, and others with the development of programs and strategies to reduce bullying and other aggressive behaviors; and

(6) urges parents and other caretakers of children and adolescents to: (a) be actively involved in their child's school and community activities; (b) teach children how to interact socially, resolve conflicts, deal with frustration, and cope with anger and stress; and (c) build supportive home environments that demonstrate respect, tolerance, and caring and that do not tolerate bullying, harassment, intimidation, social isolation, and exclusion.

Providing Medical Services through School-Based Health Programs H-60.991

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984

1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and

outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.

2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.

3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.

Increasing Detection of Mental Illness and Encouraging Education D-345.994

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

Emotional and Behavioral Effects of Video Game and Internet Overuse D-60.974

Our AMA:

(1) urges agencies such as the Federal Trade Commission as well as national parent and public interest organizations such as the Entertainment Software Rating Board, and parent-teacher organizations to review the current ratings system for accuracy and appropriateness relative to content, and establish an improved ratings systems based on a combined effort from the entertainment industry and peer review;

(2) will work with key stakeholder organizations such as the American Academy of Pediatrics and the American Academy of Family Physicians to (a) educate physicians on the public health risks of media exposure and how to assess media usage in their pediatric populations and (b) provide families with educational materials on the appropriate use of video games;

(3) supports increased awareness of the need for parents to monitor and restrict use of video games and the Internet and encourage increased vigilance in monitoring the content of games purchased and played for children 17 years old and younger;

(4) encourages organizations such as the Centers for Disease Control and Prevention, the National Science Foundation, and the National Institutes of Health to fund quality research (a) on the long-term beneficial and detrimental effects not only of video games, but use of the

Internet by children under 18 years of age; and (b) for the determination of a scientifically-based guideline for total daily or weekly screen time, as appropriate; and

(5) will forward Council on Science and Public Health Report 12-A-07, Emotional and Behavioral Effects of Video Game and Internet Overuse, to the American Psychiatric Association and other appropriate medical specialty societies for review and consideration in conjunction with the upcoming revision of the Diagnostic and Statistical Manual of Mental Disorders.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 42
(A-17)

Introduced by: Yuna Kim, Carina Chang, Ashley Tarchione, Jonathan Gevorkian;
University of Nevada, Reno School of Medicine

Subject: Redistribution of Unused Prescription Drugs to Pharmaceutical Donation
and Reuse Programs

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, 23% of American adults do not refill prescriptions or do not adhere to medication
2 regimens due to cost;¹ and
3
4 Whereas, Generic drug price increased between 474% to over 18,000% from December 2012
5 to July 2015;¹⁴ and
6
7 Whereas, High prescription costs lead to worse health outcomes and negative total cost effects
8 due to increased preventable complications and emergency department visits;² and
9
10 Whereas, There is a surplus of unused medications in the US;^{3, 15} and
11
12 Whereas, In long-term care facilities alone, \$2 billion worth of medications already paid for by
13 federal and state governments are discarded annually, leaving a potential \$700 million to be
14 saved by reusing these discarded medications;^{3, 15} and
15
16 Whereas, Hospital pharmacies and other health care providers spend approximately \$1 billion
17 on the destruction of medications annually;⁹ and
18
19 Whereas, Current DEA standards of drug disposal include drug take-back programs, mail-back
20 programs, and collection receptacles, with collected prescription drug being destroyed by
21 incineration;^{11, 4} and
22
23 Whereas, The “AMA supports access to safe, convenient, and environmentally sound
24 medication return for unwanted prescription medications” by working with other organizations to
25 form authorized medication collectors (H-135.925) (H-135.936); and
26
27 Whereas, Several state laws have systems and procedures allowing for the return and
28 redistribution of unused prescription drugs to certain health care facilities;¹⁰ and
29
30 Whereas, 38 states have passed pharmaceutical donation and reuse legislation for non-
31 controlled substances, and 20 states have created operational pharmaceutical donation and
32 reuse programs dedicated to collecting unused medications to redistribute to patients for little or
33 no cost;^{5,10} and
34

35 Whereas, The determination of recipients of legally redistributed prescription medications are
36 determined by state regulations and the Department of Human Resources;¹⁰ and
37

38 Whereas, The safe return and reuse of prescription medications allows for increased access to
39 prescription medications, as demonstrated by Oklahoma's Drug Recycling Program, which has
40 redistributed over 200,000 prescriptions worth \$20 million to those in need since 2004;⁶ and
41

42 Whereas, A common obstacle to establishing a pharmaceutical donation and reuse program is
43 the absence of funding, as depicted by Texas's Drug Donation Pilot Program;⁷ and
44

45 Whereas, An analysis of the Medicaid State Vendor Drug Program showed that there would be
46 increased costs to redesign rebate and pharmacy record systems;¹³ and
47

48 Whereas, The funding to maintain redistribution programs is primarily dependent on donations
49 from nonprofit organizations, public donations, and/or a percentage of the cost to the drug
50 distributors that was originally intended for destruction of the prescription drugs;¹² and
51

52 Whereas, In a time of persistently rising prescription drug costs, establishing pharmaceutical
53 donation and reuse programs not only allows for the proper recycling of these drugs, but also for
54 increased access to prescription drugs by the 28 million Americans who are unable to afford
55 their medications;⁸ therefore be it
56

57 RESOLVED, That our AMA acknowledge funding as the main reason for a state's inability to
58 implement an operational drug donation program; and be it further
59

60 RESOLVED, That our AMA draft and promote model legislation aimed at developing better
61 funding for drug donation programs on the state level provided these programs follow the quality
62 assurance guidelines set by existing AMA Policy H-280.959.

Fiscal note:

Date received:

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RELEVANT AMA POLICY:

Medications Return Program H-135.925

1. Our AMA supports access to safe, convenient, and environmentally sound medication return for unwanted prescription medications
2. Our AMA supports such a medication disposal program be fully funded by the pharmaceutical industry, including costs for collection, transport and disposal of these materials as hazardous waste.
3. Our AMA supports changes in federal law or regulation that would allow a program for medication recycling and disposal to occur.

Contamination of Drinking Water by Pharmaceuticals and Personal Care Products D-135.993

Our AMA supports the EPA and other federal agencies in engaging relevant stakeholders, which may include, but is not limited to the AMA, pharmaceutical companies, pharmaceutical retailers, state and specialty societies, and public health organizations in the development of

guidelines for physicians and the public for the proper disposal of pharmaceuticals and personal care products to prevent contamination of drinking water systems.

Recycling of Nursing Home Drugs H-280.959

Our AMA supports the return and reuse of medications to the dispensing pharmacy to reduce waste associated with unused medications in long-term care facilities (LTCFs) and to offer substantial savings to the health care system, provided the following conditions are satisfied: (1) The returned medications are not controlled substances. (2) The medications are dispensed in tamper-evident packaging and returned with packaging intact (e.g., unit dose, unused injectable vials and ampules). (3) In the professional judgment of the pharmacist, the medications meet all federal and state standards for product integrity. (4) Policies and procedures are followed for the appropriate storage and handling of medications at the LTCF and for the transfer, receipt, and security of medications returned to the dispensing pharmacy. (5) A system is in place to track re-stocking and reuse to allow medications to be recalled if required. (6) A mechanism (reasonable for both the payer and the dispensing LTC pharmacy) is in place for billing only the number of doses used or crediting the number of doses returned, regardless of payer source.

Proper Disposal of Unused Prescription and Over-the-Counter (OTC) Drugs H-135.936

1. Our AMA supports initiatives designed to promote and facilitate the safe and appropriate disposal of unused medications.
2. Our AMA will work with other national organizations and associations to inform, encourage, support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations.
3. Our AMA will work with other appropriate organizations to develop a voluntary mechanism to accept non-controlled medication for appropriate disposal or recycling.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 43
(A-17)

Introduced by: Parth Trivedi, Icahn School of Medicine at Mount Sinai
Subject: Increased Use of Body-Worn Cameras by Law Enforcement Officers
Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1
2
3 Whereas, “Police officers are more risk averse and cautious about their actions when wearing
4 on-officer video technology”;¹ and
5
6 Whereas, Police officers using body-worn cameras are about half as likely to use force
7 compared to officers who didn’t have body-worn cameras;² and
8
9 Whereas, During the course of a study, police officers using body-worn cameras experienced a
10 47.7% decline in the number of complaints received, compared to a 7.4% decline in the number
11 of complaints received by a control group of officers not wearing body-cameras;³ and
12
13 Whereas, After using body-worn cameras, most police officers agree that use of a body-worn
14 camera “provides a more accurate account of an incident” and “improves the quality of
15 evidence”;³ and
16
17 Whereas, Our AMA has affirmed that “that physical and verbal violence between law
18 enforcement officers and public citizens, particularly within racial and ethnic minority
19 populations, is a social determinant of health” (H-515.955); and
20
21 Whereas, AMA policy states that our AMA will “facilitate the development and implementation of
22 a comprehensive, long-range, coordinated strategy to address issues and concerns affecting
23 minorities, including minority health,” including the “development, coordination, and
24 strengthening of AMA resources devoted to minority health issues” (H-350.971); therefore be it
25
26 RESOLVED, that our AMA advocate for legislative, administrative, or regulatory measures to
27 expand funding for (1) the purchase of body-worn cameras and (2) training and technical
28 assistance required to implement body-worn camera programs.

Fiscal note: TBD

Date received: 04/20/2017

References:

1. Ready JT, Young JTN. *The impact of on-officer video cameras on police-citizen contacts: findings from a controlled experiment in Mesa, AZ*. Journal of Experimental Criminology. 2015;11: 445. doi:10.1007/s11292-015-9237-8
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RELEVANT AMA AND AMA-MSS POLICY:**H-515.955 Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes**

1. Our AMA encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Our AMA affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Our AMA encourages the Centers for Disease Control and Prevention as well as state and local health departments and agencies to research the nature and public health implications of violence involving law enforcement.

H-350.971 Initiatives Regarding Minorities

The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components:

- (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;
- (2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;
- (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;

- (4) Response to inquiries and concerns of minority physicians and medical students; and
- (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.

H-145.977 Use of Conducted Electrical Devices by Law Enforcement Agencies

Our AMA: (1) recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) that is modeled after available national guidelines; (2) encourages additional independent research involving actual field deployment of CEDs to better understand the risks and benefits under conditions of actual use. Federal, state, and local agencies should accurately report and analyze the parameters of CED use in field applications; and (3) policy is that law enforcement departments and agencies have a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to CEDs

H-215.9771 - Guns in Hospitals

1. The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:

A. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.

B. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.

C. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.

D. Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.

E. Policies should undergo periodic reassessment and evaluation.

F. Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.

2. Our AMA will advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present.

440.054MSS Increase Advocacy and Research into the Effects of Police Brutality on Public Health

Outcomes: AMA-MSS will ask the AMA to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly members of ethnic and racial minority communities. (MSS Res 32, A-15) (AMA Res 910, I-15 Not Considered) (AMA Res 406, A-16 Adopted as Amended)

AMERICAN MEDICAL ASSOCIATION
Medical Student Section

Resolution 44
(A-17)

Introduced by: Alexandra Rojek, UCSF School of Medicine; Edward Walton, Wayne State University SOM; Katrina Wolfe, Creighton University SOM; Trevor Cline, UC Davis School of Medicine

Subject: Patient Safety During Handoffs and Transfers of Care

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 WHEREAS, The Joint Commission has reported that greater than 80% of “sentinel events”, or a
2 serious medical error involving death or physical harm, are caused by failures in
3 communication, continuity of care, and care planning;¹ and
4

5 WHEREAS, Handoff of patient care involves transfer of primary teams between events or shifts,
6 and has been described as high-risk and error-prone patient care events;² and
7

8 WHEREAS, Barriers to safe and effective transfers include inaccurate or incomplete information
9 transfer, lack of consistency, organization, and standardization;³ and
10

11 WHEREAS, A recent study found that implementation of a handoff protocol and education for
12 nurses reduced medical error at a large hospital within the US;⁴ and
13

14 WHEREAS, The Joint Commission reported that communication breakdowns were the leading
15 cause of reported sentinel events between 1995 and 2006;⁵ and
16

17 WHEREAS, In the setting of inter hospital transfers, where there is higher risk of poor
18 communication leading to delays in care and patient risk, handover tools showed a reduction in
19 in-hospital mortality;⁵ and
20

21 WHEREAS, The use of standardized handoff guidelines, called ‘time-outs’ has been
22 implemented in anesthesia and surgical handoffs, and has been included as a current
23 recommendation of the National Patient Safety Goals by the Joint Commission;⁶ and
24

25 WHEREAS, It has been shown that effective implementation of such handoff time-outs using a
26 structured electronic checklist improves transfer and retention of critical information;³ and
27

28 WHEREAS, AMA policy (D-310.956) recognizes the importance of safe and effective handoff
29 procedures for trainees and promotes the integration of such handoffs in electronic medical
30 records, it does not recognize the impact of such handoffs in all patient care transfer settings
31 and the threat to patient safety; and
32

33 WHEREAS, AMA policy (D-160.944) promotes the improvement and standardization of
34 information sharing through handoffs, as well as the development of long term initiatives to

1 optimize such transfers, it does not call for integration with electronic medical records; therefore
2 be it

3
4 RESOLVED, That our AMA amend HOD policy D-160.944 by addition as follows:

5
6 Our AMA will: (1) work to improve and standardize the flow of critical information across
7 the spectrum of care through collaboration with long-term care stakeholders, including
8 the American Medical Directors Association (AMDA); (2) work with other stakeholder
9 organizations including the AMDA in an effort to develop standardized transfer forms
10 and to promote educational initiatives that optimize transfer of information across the
11 spectrum of care; (3) work with the Physician Consortium for Performance Improvement
12 to develop specific measures appropriate for recognizing the work effort that assure
13 transitions of care across the continuum of care to be safe, patient centered and
14 outcome driven; and (4) work with appropriate stakeholders to develop and disseminate
15 a standardized methodology for patient handoffs between care teams in the hospital and
16 from the hospital to the community setting utilizing best practices for integration with
17 existing electronic medical records; and (5) work with other stakeholder organizations
18 including the AMDA to develop educational initiatives and long-range projects to
19 optimize the transfer of information across the spectrum of acute and long-term care.

Fiscal note: TBD

Date received: 04/20/2017

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4. Patton, L. J. *et al.* Ensuring Safe Transfer of Pediatric Patients: A Quality Improvement Project to Standardize Handoff Communication. *Journal of Pediatric Nursing*. 2017.
5. Theobald, C. N. *et al.* Effect of a Handover Tool on Efficiency of Care and Mortality for Interhospital Transfers. *Journal Of Hospital Medicine*. 2017; 12.1, 23-28.
6. The Joint Commission. National Patient Safety Goals Effective January 2017: Hospital Accreditation Program.

RELEVANT AMA AND AMA-MSS POLICY:

Transfer of Care for Resident and Fellow Physicians in Training D-310.956

Our AMA: (1) working with other organizations and stakeholders, will identify best practices including the presence, quality, and utilization of computerized systems for transfer of care in training programs in all specialties; (2) will encourage the ACGME to add to the Institutional Requirements a requirement that GME training institutions ensure that trainees in all specialties are provided with an effective, systematic approach for handoffs of clinical information and

transfer of care between trainees within their institution; and (3) will advocate for the use of federal dollars in existing Health Information Technology (HIT) initiatives to sponsor systems that enable transfers of care that are integral to any well-functioning electronic medical record.

Recognizing Transitions of Care for Performance Improvement D-160.944

Our AMA will: (1) work to improve and standardize the flow of critical information across the spectrum of care through collaboration with long-term care stakeholders, including the American Medical Directors Association (AMDA); (2) work with other stakeholder organizations including the AMDA in an effort to develop standardized transfer forms and to promote educational initiatives that optimize transfer of information across the spectrum of care; (3) work with the Physician Consortium for Performance Improvement to develop specific measures appropriate for recognizing the work effort that assure transitions of care across the continuum of care to be safe, patient centered and outcome driven; and (4) work with other stakeholder organizations including the AMDA to develop educational initiatives and long-range projects to optimize the transfer of information across the spectrum of acute and long-term care.

Surgical Safety Checklists H-475.982

Our AMA: (1) supports the use of evidence-based surgical safety checklists that best fit the needs and processes of care in specific environments and surgical disciplines, including the validated World Health Organization (WHO) surgical safety checklists and their variants when they are appropriate and adapted to local conditions; (2) recommends that the effectiveness of all checklists be demonstrated both during development and on local implementation, and that checklists be adapted to maximize their effectiveness under local conditions; and (3) supports further research on checklists, including their long-term utility, their situational applicability, the ancillary activities and organizational changes that impact their effectiveness, and the specific mechanisms by which they impact outcomes

Transfer of Emergency Patients H-130.982

Our AMA: (1) supports the following principles for the transfer of emergency patients: (a) All physicians and healthcare facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility transfer of an unstabilized emergency patient should be undertaken only for appropriate medical purposes, i.e., when in the physician's judgment it is in the patient's best interest to receive needed medical service care at the receiving facility rather than the transferring facility; and (c) all interfacility transfers of emergency patients should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges county medical societies to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians' Guidelines for Transfer of Patients should be reviewed in the development of such community protocols and agreements; and (3) urges state medical associations to encourage and provide assistance to their county medical societies as they develop such protocols and interhospital agreements with their local hospitals.

Duty Hours Policy H-310.907

3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.

Refusal of Appropriate Patient Transfers H-130.961

The AMA (1) continues to urge county medical societies to develop, with their local hospitals, protocols, and interhospital transfer agreements, and to urge state medical associations to assist their county societies as they develop such agreements; and

(2) encourages county medical societies and local hospitals to review and utilize the AMA Principles for the Transfer of Emergency Patients and the American College of Emergency Physicians' Principles of Appropriate Interhospital Patient Transfer as they develop local transfer arrangements.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 45
(A-17)

Introduced by: Parth Trivedi, Icahn School of Medicine

Subject: Collecting and Releasing Data on Law Enforcement Use of Force

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1
2

3 Whereas, The Death in Custody Reporting Act (DCRA) requires “states and federal law
4 enforcement agencies to submit data to the department about civilians who died during
5 interactions with law enforcement or in their custody”;¹ and

6

7 Whereas, The Department of Justice has acknowledged that while Congress passed the DCRA,
8 there is no legislation that requires law enforcement agencies to report *non-lethal* uses of force;¹
9 and

10

11 Whereas, The Department of Justice has launched an initiative to create a national use-of-force
12 database, but participation in this program is voluntary and data would be self-reported;^{1,2} and

13

14 Whereas, Self-reported data from law enforcement officials has proved to be unreliable in the
15 past;³ therefore be it

16

17 RESOLVED, that our AMA advocate for legislative, administrative, or regulatory measures that
18 mandate data reporting on all uses-of-force by law enforcement officials in all legal jurisdictions
19 nationwide.

Fiscal note: TBD

Date received: 04/20/2017

References:

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2. “Use-of-Force.” Federal Bureau of Investigation. <https://ucr.fbi.gov/use-of-force> Accessed 4/17/2017

3. Lowery W. "How many police shootings a year? No one knows." Washington Post. https://www.washingtonpost.com/news/post-nation/wp/2014/09/08/how-many-police-shootings-a-year-no-one-knows/?utm_term=.883768dae8af Sept 8th, 2014. Accessed 4/17/2017

RELEVANT AMA AND AMA-MSS POLICY:

H-515.955 Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes

1. Our AMA encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Our AMA affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Our AMA encourages the Centers for Disease Control and Prevention as well as state and local health departments and agencies to research the nature and public health implications of violence involving law enforcement.

H-350.971 Initiatives Regarding Minorities

The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components:

- (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;
- (2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;
- (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
- (4) Response to inquiries and concerns of minority physicians and medical students; and
- (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.

440.054MSS Increase Advocacy and Research into the Effects of Police Brutality on Public Health

Outcomes: AMA-MSS will ask the AMA to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly members of ethnic and racial minority communities. (MSS Res 32, A-15) (AMA Res 910, I-15 Not Considered) (AMA Res 406, A-16 Adopted as Amended)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 46
(A-17)

Introduced by: Rugaya Abaza, David Carney, Parnia Salehi, Girgis Fahmy, Morehouse School of Medicine; David Lee, Western Michigan University School of Medicine

Subject: Identifying and Addressing Food Insecurity and Food Deserts Nationwide

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, Food insecurity is defined by the United States Department of Agriculture (USDA) as
2 the limited or uncertain availability of nutritionally adequate and safe foods or limited or
3 uncertain ability to acquire acceptable foods in socially acceptable ways;¹ and
4

5 Whereas, Food security is defined as food access by all members at all times to enough food
6 for an active, healthy life, including at minimum the ready availability of nutritionally adequate
7 and safe foods and the assured ability to acquire acceptable foods in socially acceptable ways;¹
8 and
9

10 Whereas, A food desert is defined as parts of the country where a minimum of 500 people or at
11 least 1/3 of the census population lives more than one mile from a supermarket providing fresh
12 fruits, vegetables, and other healthful whole foods;^{1,2} and
13

14 Whereas, 12.7% of all households in America were food insecure in 2015;³ and
15

16 Whereas, Food insecure girls who participated in food assistance programs are at 68% reduced
17 odds of being overweight when compared with food insecure girls in non-participating
18 households when controlling for other factors;⁴ and
19

20 Whereas, Processed foods found in food insecure areas often violate the 2015-2020 USDA
21 Dietary Guidelines for those over the age of 14 due to their high content of saturated fat, added
22 sugar, and sodium;⁵ and
23

24 Whereas, 11.5 million Americans who fall under the poverty line live in a food desert;⁶ and
25

26 Whereas, Neighborhood healthy food environment was associated with a 10% decrease in the
27 incidence of obesity per standard deviation increase in the neighborhood score which was
28 calculated based on walking environment and availability of healthy food;⁷ and
29

30 Whereas, Obese individuals live 9.44 fewer years than their reference weight counterparts and
31 spend 30% more on healthcare costs;^{8,9} and
32

33 Whereas, Although the United States Department of Agriculture's (USDA) Food Access
34 Research Atlas does exclude stores that are not large enough to have a variety of food and
35 stores that are not accessible to everyone such as military commissaries and food warehouses
36 that require paid membership, it does not identify low-cost versus high-cost food sources or take

1 into account prices of healthy food at these stores, and relies on geographic proximity to define
2 accessibility, with the exception of a category adjusted for lack of vehicle availability;¹⁰ and
3

4 Whereas, The USDA recognizes, based on the increased number of Low-Income, Low-Access
5 (LiLa) neighborhoods and on the increased number of food stores from 2010 to 2015, that
6 income and resource constraints are better predictors of low access to healthy food sources
7 than geographic proximity;¹⁰ and
8

9 Whereas, When taking into account cost of food sold in geographically accessible stores, areas
10 including those affected by gentrification that are not currently considered food deserts may still
11 lack functionally accessible healthy food options for low-income individuals;¹¹ and
12

13 Whereas, In a study done in Portland, Oregon, the percent increase in white population was
14 found to correlate to the distance to the nearest low cost affordable food option where
15 individuals living in an area that saw a 5.08% increase in their white population had geographic
16 access to healthy foods 0.37 miles away, but had to travel 2.55 miles to reach the closest
17 affordable food option;¹¹ and
18

19 Whereas, In Portland, 81% of individuals living in poverty residing more than one mile from a
20 low-cost store also reside in an area not currently identified as a food desert by geographic
21 proximity, even though the majority of these individuals must travel on average 1.8 miles past
22 the nearest grocery store to arrive at the nearest low-cost store;¹¹ and
23

24 Whereas, Current methods of food desert identification that do not adjust for vehicle ownership
25 are more likely to understate inaccessibility to healthy food;¹² and
26

27 Whereas, High crime rates surrounding food sources act as a barrier to access to healthy food
28 especially in those travelling by foot or by public transportation;¹² and
29

30 Whereas, An analysis of educational interventions aimed at improving student health showed
31 that introduction of nutrition education into school curriculum combined with regular activities at
32 the school for a duration of longer than a year was found to be effective in reducing the number
33 of overweight and obese students as well as increasing fruit and vegetable consumptions in the
34 students' diets;¹³ and
35

36 Whereas, Nutrition education programs that incorporate gardening into student curriculum
37 engage students in food sourcing and increase accessibility to healthy food options;¹³ and
38

39 Whereas, School gardens in New York City have supplied produce to school cafeteria meals in
40 over 50 schools across the city;¹⁴ and
41

42 Whereas, Community gardens have been shown to increase consumption of fruits and
43 vegetable in inner city households and provide significant amounts of produce to community
44 members;¹⁵ and
45

46 Whereas, Community gardens contribute 2 million pounds of fresh produce to citizens of
47 Philadelphia each year and a study in Flint Michigan showed that participation in community
48 gardens increased fruits and vegetable consumption in residents' diets;¹⁵ therefore be it
49

50 RESOLVED, That our AMA-MSS advocate for research on the impact of factors influencing
51 functional access to food including but not limited to gentrification, transportation, and crime
52 rates on the development of food deserts; and be it further

1 RESOLVED, That our AMA-MSS advocate for the creation of new tools aimed at identifying
2 food deserts taking into account cost of food in geographically accessible stores or modification
3 of existing tools for identification of food deserts to include consideration of affordability in the
4 establishment of accessibility of healthy food sources; and be it further

5
6 RESOLVED, That our AMA-MSS will support current efforts by the United States Department of
7 Agriculture in the incorporation of nutrition education programs focusing on sustainable food
8 sourcing and the impact of healthy foods on overall well-being including but not limited to those
9 involving school and community garden building and education on healthy eating habits.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Addressing Obesity D-440.954

1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention. 2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions). (BOT Rep. 11, I-06), (Reaffirmation A-13), (Appended: Sub. Res. 111, A-14), (Modified: Sub. Res. 811, I-14)

Obesity as a Major Public Health Problem H-150.953

Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and (8) urge the appropriate federal agencies to

work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity. (CSA Rep. 6, A-99), (Reaffirmation A-09), (Reaffirmed: CSAPH Rep. 1, A-09), (Reaffirmation A-10), (Reaffirmation I-10) (Reaffirmation A-12), (Reaffirmed in lieu of Res. 434, A-12), (Reaffirmation A-13), (Reaffirmed: CSAPH Rep. 3, A-13)

Obesity as a Major Health Concern H-440.902

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat overweight and obese patients. (Res. 423, A-98), (Reaffirmed and Appended: BOT Rep. 6, A-04), (Reaffirmation A-10), (Reaffirmed in lieu of Res. 434, A-12), (Reaffirmation A-13)

Combating Obesity and Health Disparities H-150.944

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of products low in fat and cholesterol. (Res. 413, A-07), (Reaffirmation A-12), (Reaffirmation A-13)

Prevention of Obesity Through Instruction in Public Schools H-170.961

Our AMA will urge appropriate agencies to support legislation that would require meaningful yearly instruction in nutrition, including instruction in the causes, consequences, and prevention of obesity, in grades 1 through 12 in public schools and will encourage physicians to volunteer their time to assist with such an effort. (Res. 426, A-12)

Improvements to Supplemental Nutrition Programs H-150.937

Our AMA supports: (1) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (2) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (3) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program. (Res. 414, A-10), (Reaffirmed: A-12), (Reaffirmed: A-13), (Reaffirmed: A-14), (Reaffirmed: I-14), (Reaffirmed: A-15)

Food Stamp Incentive Program D-150.983

Our AMA supports legislation to provide a meaningful increase in the value of food stamps

when used to purchase fruits and vegetables. (Res. 405, A-07), (Reaffirmed: A-13), (Reaffirmed: A-14)

Increasing the Consumption of Healthy Fresh Foods in Food Desert Communities Using Mobile Produce Vendor Programs 150.029MSS:

AMA-MSS will ask the AMA to support expanding the use of current state and federal food assistance programs (e.g. Supplemental Nutrition Assistance Program; Special Supplemental Nutrition Program for Women, Infants, and Children Fruit and Vegetable Cash Value Voucher; and the US Farm Bill) to include purchasing fruits and vegetables from licensed and/or certified healthy mobile produce vendors. (MSS Res 12, I-14) (Existing Policy Reaffirmed in Lieu of AMA Res 405, A-15)

Decreasing Incidence of Obesity and Negative Sequelae by Reducing the Cost Disparity Between Calorie-Dense, Nutrition Poor Foods and Nutrition-Dense Foods 150.020MSS:

AMA-MSS will ask the AMA to (1) support efforts to decrease the price gap between calorie dense, nutrition poor (CDNP) foods and naturally nutrition dense (ND) foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrolment, of existing programs that seek to improve nutrition and reduce obesity such as the Farmer's Market Nutrition Program (FMNP) as a part of the Women, Infants, and Children (WIC) program; and (2) support the novel application of FMNP to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of ND foods in wider food distribution venues than solely farmer's markets as part of WIC. (MSS Res 23, I-09) (AMA Res 414, A-10 Adopted [H-150.937]) (Reaffirmed: MSS GC Rep A, I-14)

Programs to Combat Food Deserts 150.026MSS:

AMA-MSS will ask the AMA to amend policy D-150.978 by insertion and deletion as follows: "Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through the US Farm Bill tax incentive programs, community-level initiatives and other federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems. (MSS Res 19, I-12) (AMA Res 204, A-13 Adopted [D-150.978])

Increasing Healthy Food Choices Among Families Supported by the Supplemental Nutrition Assistance Program 150.028MSS:

AMA-MSS will ask the AMA to advocate for positive financial incentives to encourage healthier food purchases for Supplemental Nutrition Assistance Program participants. (MSS Res 35, A-14) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 905, I-14)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 47
(A-17)

Introduced by: Hongan Chen, Baylor College of Medicine; Courtney Collins, University of Kentucky College of Medicine

Endorsed by: Region 3, Region 5

Subject: Improving Recognition and Diagnosis of Fragile-X Diseases

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, To date fragile X syndrome (FXS) is the leading form of inherited intellectual disability
2 and the most common single-gene cause of autism spectrum disorder; it may also be
3 associated with a spectrum of other medical and developmental issues;^{1,2} and
4

5 Whereas, A survey study reported FXS symptoms in children are first observed by their parents
6 at an average age between 12-16 months; however, there is an average lag time of 24-26
7 months between initial observation of symptoms and diagnosis;³ and
8

9 Whereas, Despite current recommendations, FXS is not routinely considered when diagnosing
10 intellectual disabilities, as indicated by a study response of 27% of parents with a child
11 diagnosed with FXS had visited a doctor more than 10 times before FXS testing was ordered,
12 and 37.6% of parents reported over 10 visits were required before the diagnosis of FXS, a
13 source of frustration for the parents;³⁻⁵ and
14

15 Whereas, The most recent study to survey average age of FXS diagnosis was in 2009 and may
16 be outdated;³ and
17

18 Whereas, Early diagnosis of FXS is also beneficial to the family, allowing for genetic counseling
19 and family planning;⁶ and
20

21 Whereas, A study surveying parents of children with FXS reported 27% of the families with an
22 affected firstborn son and 39% of those with an affected firstborn daughter had a second child
23 with FXS before the diagnosis of their first child, further demonstrating the burden a delayed
24 diagnosis can have on families;⁷ and
25

26 Whereas, In all 50 states, early diagnosis of FXS in affected children immediately qualifies them
27 for intervention programs under the Individuals with Disabilities Education Act Part C, benefitting
28 both the child and the family;⁸ and
29

30 Whereas, While there is no proven treatment of FXS, prompt therapeutic interventions following
31 early FXS diagnosis is beneficial for and can significantly improve quality of life for FXS
32 individuals, who have a normal life expectancy;^{9,10} and
33

1 Whereas, Maternal stress, anger, anxiety and depressive symptoms are strongly associated
2 with an affected child's behavioral problems, suggesting that caregiver burden can be reduced
3 with effective behavioral interventions;¹¹ and
4

5 Whereas, A 2015 review of 31 behavioral intervention studies for individuals with FXS reported
6 the majority of studies showed at least some improvement in the targeted behavior; however,
7 the review ultimately concluded more research of higher quality on specific strategies is needed
8 to validate the use of behavioral interventions as treatment for FXS;¹² and
9

10 Whereas, Fragile X-associated disorders (FXDs) refer collectively to three syndromes related to
11 fragile X mental retardation (FMR1) gene dysfunction;¹³ and
12

13 Whereas, Aside from FXS, the other two syndromes that comprise FXD are fragile X-associated
14 primary ovarian insufficiency syndrome (FXPOI) and fragile X-associated tremor/ataxia
15 syndrome (FXTAS);¹³ and
16

17 Whereas, Until recently, FMR1 premutation carriers were thought to be phenotypically normal,
18 but it is now known that FXTAS may occur in about 45.5% of male FMR1 premutation carriers
19 and FXPOI in about 20% of female carriers;^{13,14} and
20

21 Whereas, Early diagnosis of FXS for a child may have bearing on other family members who
22 are FMR1 premutation carriers and may be at risk of FXTAS and similarly, diagnosis of FXTAS
23 in an individual may have implications for the offspring of said person;⁵ and
24

25 Whereas, The American College of Medical Genetics and Genomics (ACMG) recommends
26 FMR1 testing for, "individuals of either sex presenting with mental retardation, autism, or
27 developmental delay; individuals seeking reproductive counseling with a family history of fragile
28 X syndrome or undiagnosed mental retardation; fetuses of known carrier mothers; women
29 experiencing reproductive problems with elevated FSH; or men and women with late onset
30 tremor and ataxia of unknown origin";¹⁵ and
31

32 Whereas, FXTAS is "the most common known single-gene form of tremor and ataxia";¹⁶ and
33

34 Whereas, FXTAS is often underdiagnosed due to a lack of physician awareness of the
35 syndrome and to its nonspecific symptoms that are common to the elderly;¹⁶ and
36

37 Whereas, Recent research suggests FXTAS has a broader phenotype than initially proposed,
38 the recognition of which may appropriately increase FXTAS diagnoses;¹⁷ and
39

40 Whereas, The misdiagnosis of FXTAS is a major problem; a 2005 study reported 56 patients
41 receiving 98 diagnoses prior to that of FXTAS, with the most common being parkinsonism,
42 tremor and ataxia;¹⁶ and
43

44 Whereas, The under-diagnosis and misdiagnosis of FXTAS not only affects the patient but also
45 the patient's family members due to the genetic component of the disease;¹⁷ and
46

47 Whereas, The only treatment for FXTAS is therapy aimed at slowing disease progression and
48 providing symptomatic relief as there has been no clinical trials for pharmaceuticals aimed at
49 stopping FXTAS progression;^{16,18} and
50

51 Whereas, Newborn screening (NBS) for FMR1 mutations is not currently included in the NBS
52 program, in part because of lack of medical treatment, data on early-intervention benefits and of

1 a cost-effective screening test at the time of the decision in 2005 by the American College of
2 Medical Genetics;^{19,20} and

3
4 Whereas, To date, both pharmacological and behavioral therapies for FXS have been
5 developed and researched with promising results;²¹⁻²³ and

6
7 Whereas, A rapid PCR-based screening test identifying FMR1 allele expansions has been
8 developed for less than \$5 per test, and is predicted to approach \$1 with appropriate scale-up;²²
9 and

10 Whereas, Established newborn screening guidelines indicate a disease must have available
11 screening, diagnostics, and treatment to which FMR1 mutation screening has had improvement
12 in these areas since its last consideration in 2005;^{22,24,25} and

13
14 Whereas, In a 2011 pilot study of NBS for FMR1 mutations had, 63% of couples accepted the
15 screening;²⁷ and

16
17 Whereas, Musci et al reported population-based FMR1 prenatal screening to be cost-effective
18 and clinically desirable;²⁸ and

19
20 Whereas, A study on attitudes of patients offered prenatal FXS carrier screening concluded
21 limited pretest knowledge and posttest retention of FXS information, with only 33% of
22 participants having heard of FXS prior to study participation, highlighting the importance and
23 necessity of appropriate educational tools and counseling infrastructure;²⁹ and

24
25 Whereas, Genetic counseling for FXS is typically more challenging and time-consuming than
26 counseling for Down Syndrome due to less patient familiarity with FXS;³⁰ and

27
28 Whereas, Existing AMA-MSS policy supports efforts to determine guidelines for the “best
29 practices of genetic counseling” (200.019MSS) and “encourages continued research on the
30 NBS for certain diseases and the development of new NBS technology” (245.014 MSS); and

31
32 Whereas, Existing AMA policy supports the standardization of NBS, the improvement of genetic
33 testing and counseling services, and the education of physicians on early intervention with
34 patients who display developmental delay; therefore be it

35
36 RESOLVED, That our AMA support efforts to emphasize expedited and definitive diagnosis of
37 Fragile-X Syndrome (FXS), such as by encouraging adherence to ACMG recommendations for
38 FMR1 genetic testing by physicians for patients with identified developmental delays; and be it
39 further

40
41 RESOLVED, That with regard to the full spectrum of fragile-X diseases (FXD)—currently
42 comprised of FXS, fragile X-associated tremor/ataxia syndrome FXTAS and fragile X-
43 associated Primary Ovarian Insufficiency (FXPOI)—our AMA endorse efforts to educate and
44 raise awareness of FXD among physicians, healthcare professionals, and the general
45 public through the development of pre- and post-test educational tools and counseling
46 resources; and be it further

47
48 RESOLVED, That our AMA support continued research to accurately classify the expanded
49 diagnostic criteria of FXTAS and encourage the dissemination of this criteria to increase
50 appropriate FXTAS diagnoses; and be it further

51

1 RESOLVED, That our AMA (1) recognizes the dearth of existing empirical research on the
2 efficacy of behavioral interventions for affected FXS individuals; (2) calls for reliable and
3 clinically meaningful research on FXS-specific behavioral interventions and outcomes to
4 validate and standardize treatment recommendations for affected FXS individuals and their
5 families; and be it further
6

7 RESOLVED, That our AMA call for a follow-up study to evaluate current average age of FXS
8 diagnosis to inform the medical community and other concerned parties the efficacy of ACMG
9 recommendations for FXS screening and other interventions seeking to improve FXS diagnosis;
10 and be it further
11

12 RESOLVED, That our AMA encourage continued FMR1 newborn screening (NBS) pilot
13 research to further determine the risks and benefits of such screening, advocate for
14 development and dissemination of best practice guidelines for offering voluntary
15 preconception/carrier and prenatal FMR1 screening and urge development of early intervention,
16 genetic counseling and educational infrastructure to support the expansion of screening.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Standardization of Newborn Screening Programs H-245.973

Our AMA: (1) recognizes the need for uniform minimum newborn screening (NBS) recommendations; and (2) encourages continued research and discussions on the potential benefits and harms of NBS for certain diseases. (CSAPH Rep. 9, A-06 Reaffirmed in lieu of Res. 502, A-09)

Improving Genetic Testing and Counseling Services H-480.944

Our AMA supports: (1) appropriate utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) the development and dissemination of guidelines for best practice standards concerning pre- and post-test genetic counseling; and (3)

research and open discourse concerning issues in medical genetics, including genetic specialist workforce levels, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic testing and counseling on patient care and outcomes. (Res. 913, I-16)

Early Intervention for Individuals with Developmental Delay H-90.969

(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population. (CCB/CLRPD Rep. 3, A-14)

AMA Endorsement of Screening Tests or Standards G-600.064

(1) Delegates, state, or specialty societies submitting a resolution seeking endorsement or AMA adoption of specific screening tests must also submit an evidence-based review that determines the strength or quality of the evidence supporting their request, and that evaluates the degree to which the test satisfies the minimal criteria for validating the appropriateness of the screening test, which are: (a) the test must be able to detect the target condition earlier than without screening and with sufficient accuracy to avoid producing large numbers of false-positive and false-negative results; and (b) screening for and treating persons with early disease should improve the likelihood of favorable health outcomes compared with treating patients when they present with signs or symptoms of disease. (2) This review will be made available to the reference committee, which will either recommend to the House of Delegates that the resolution be referred or not be adopted. (CSA Rep. 7, A-02 CC&B Rep. 3, I-08 Reaffirmed: CCB/CLRPD Rep. 3, A-12)

Medical Care of Persons with Developmental Disabilities H-90.968

1. Our AMA encourages: (A) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (B) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (C) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (D) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (E) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (F) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (G) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.

2. Our AMA seeks: (A) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (B) insurance industry

and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals.

3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (A) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (B) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them. (CCB/CLRPD Rep. 3, A-14 Appended: Res. 306, A-14)

Multiplex DNA Testing for Genetic Conditions H-480.966

Policy of the AMA is that: (1) tests for more than one genetic condition should be ordered only when clinically relevant and after the patient or parent/guardian has had full counseling and has given informed consent; (2) efforts should be made to educate clinicians and society about genetic testing; and (3) before genetic testing, patients should be counseled on the familial implications of genetic test results, including the importance of sharing results in instances where there is a high likelihood that a relative is at risk of serious harm, and where the relative could benefit from early monitoring or from treatment. (CEJA Rep. 1, I-96 Appended: BOT Rep. 16, I-99 Modified: CSA Rep. 3, A-03 Modified: CSAPH Rep. 1, A-13)

Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems 200.019MSS

Our AMA-MSS will ask (1) That our AMA support efforts to assess the usage of genetic testing and need for counseling services, physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) , That our AMA encourage efforts to create and disseminate guidelines for best practice standards concerning counseling for genetic test results; and (3) That our AMA support further research into and open discourse concerning issues in medical genetics, including the genetic specialist workforce shortage, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic test results and counseling on patient satisfaction. (MSS Res 11, A-16).

National Minimum Newborn Screening Recommendations 245.014 MSS

AMA-MSS will ask the AMA to: (1) support and recognize a need for uniform minimum newborn screening (NBS) recommendations; (2) encourage continued research on the benefits of NBS for certain diseases and the development of new NBS technology; and (3) recommend the adoption of a national minimum uniform screening panel for newborns by establishment of model state legislation and encouragement of legislation for adoption by Congress, pending completion and a review of the evaluation by the Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children. (MSS Sub Res 27, I-04) (AMA Res 530, A-05 Referred) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 48
(A-17)

Introduced By: Ida Azizkhanian New York Medical College; Parth Trivedi, Mount Sinai School of Medicine

Subject: Promoting Education on How to Evaluate Asylum Seekers for Signs of Physical and/or Psychological Torture

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, According to INA section 208, the burden of proof is on the applicant [for
2 asylum] to establish that the applicant is a refugee;¹ and
3

4 Whereas, Physicians play a critical role in refugee status determination procedures by
5 providing medical reports to substantiate an asylum seeker's claim;² and
6

7 Whereas, The approval rate for asylum cases with a Physicians for Human Rights
8 medical evaluation is 89% while the national average for all cases is 37.5%;³ and
9

10 Whereas, A survey of 79 US allopathic medical schools found that in 2009,
11 approximately 68% of the schools did not offer any degree of Health and Human Rights
12 education;⁴ and
13

14 Whereas, A survey of the deans of 105 schools of medicine and public health revealed
15 that 62% of the deans considered it important to offer a health and human rights course
16 or module;⁴ and
17

18 Whereas, There are only 11 Physicians for Human Rights (PHR) student run asylum
19 clinics in the US and there is regional disparity in access to these PHR opportunities
20 because 7 of the 11 clinics are in the northeast of the US;⁵ and
21

22 Whereas, The United States granted asylum to 26,124 individuals in 2015;⁶ and
23

24 Whereas, The United States is the largest recipient of asylum claims among
25 industrialized nations;⁷ and
26

27 Whereas, The United States was home to about 500,000 torture survivors in 2007;⁸ and
28

29 Whereas, A refugee is defined as being someone who is unable or unwilling to return to
30 his or her country of nationality due to a "persecution or a well-founded fear of
31 persecution on account of race, religion, nationality, membership in a particular social
32 group, or political opinion;⁹ and
33
34

1 Whereas, The AMA supports the dignity of the individual, human rights and the sanctity
2 of human life (**H-65.965**); and

3
4 Whereas, the AMA endorses the World Medical Association's Declaration of Tokyo,
5 which stipulates, “physicians have an obligation to diagnose and treat victims of torture”
6 (**H-65.997**); and

7
8 Whereas, the AMA opposes torture in any country for any reason and urges appropriate
9 support for victims of torture (**H-65.981**); therefore be it

10
11 RESOLVED, That our AMA work with the LCME and the AAMC to promote the
12 education of medical students and practicing physicians on health and human rights
13 violations; and be it further

14
15 RESOLVED, That our AMA work with the LCME and AAMC to promote education and
16 formal training of medical students and practicing physicians on how to (1) recognize
17 and document the signs of physical and psychological abuse in asylum seekers (2)
18 serve as conduits for accumulating proof of refugee status.

Fiscal note: TBD

Date Received: 04/20/2017

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RELEVANT AMA POLICY:

Support of Human Rights and Freedom H-65.965

1. Our AMA continues to support the dignity of the individual, human rights and the sanctity of human life.
2. Our AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age.
3. Our AMA opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies..

Human Rights H-65.997

Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.

Human Rights and Health Professionals H-65.981

The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 49
(A-17)

Introduced by: Rijul Asri, Anastasia Bogdanovski, Samantha Cerasiello, Uttara Gadde,
Alexander Mozeika, Nicole Silva, Rutgers New Jersey Medical School

Subject: Culturally-Competent Preventative Care for Immigrant Populations

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

- 1 Whereas, Access to basic health care and preventative measures, which go beyond secondary
2 prevention screenings to include patient education, immunization, nutritional counseling, and
3 chemoprophylaxis, are primary areas of concern for immigrant populations in the U.S.^{1,2,3}; and
4
5 Whereas, The Center for Disease Control has identified vitamin deficiency and infectious
6 disease as primary areas of health concern for migrant populations coming into the U.S.
7 healthcare system⁴⁻⁸; and
8
9 Whereas, A recent report from a Task Force on Immigrant Health Care Access identified
10 numerous barriers to healthcare access faced by immigrant populations that go beyond those
11 faced by the uninsured, including "inadequate cultural and linguistic competency among health
12 care providers" and "lack of knowledge and understanding of care and coverage options
13 available for immigrants"⁹⁻¹²; and
14
15 Whereas, Sociocultural conventions, such as reservations to discuss sexual health, within
16 foreign-born and immigrant populations contribute to barriers to seeking non-emergent,
17 preventative healthcare¹³; therefore, be it
18
19 RESOLVED, That our AMA-MSS support continued efforts to gather data on the current health
20 climate of the immigrant population, and on the efficacy of preventive medicine for immigrant
21 health outcomes; and be it further
22
23 RESOLVED, That our AMA-MSS support increased access to culturally-competent preventive
24 healthcare for immigrant populations; and it be further
25
26 RESOLVED, That our AMA-MSS support more culturally-specific education and counseling for
27 immigrant patients, especially around infection prevention and nutrition, during routine and initial
28 health screenings of migrant populations; and be it further
29
30 RESOLVED, That our AMA-MSS support the development of best-practice guidelines for
31 culturally-competent preventive medicine in immigrant populations.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Addressing Immigrant Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

295.981MSS Promoting Culturally Competent Health Care: AMA-MSS will ask the AMA to encourage medical schools to offer electives in culturally competent health care with the goal of increasing awareness and acceptance of cultural differences between patient and provider. (MSS Sub Res 6, I-96) (AMA Res 306, A-97 Adopted as Amended [H-295.905]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

270.010MSS Support of Health Care to Legal Immigrants: AMA-MSS will ask the AMA to establish as policy its opposition to Federal and state legislation denying or restricting legal immigrants Medicaid and immunizations. (MSS Amended Sub Res 13, I-96) (AMA Res 211, A-97 Adopted [H-290.983]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

160.022MSS Reducing Barriers to Preventive Health Care Delivery and Compensation: AMA-MSS will ask the AMA to support both the reduction of financial barriers to the delivery of cost effective preventive health care services, and the implementation of financial incentives for cost-effective preventive medical care. (MSS Res 20, I-11) (Reaffirmed Existing Policy in Lieu of AMA Res 107, A-12) (Modified: MSS GC Report A, I-16)

170.001MSS Prevention & Health Education: AMA-MSS supports the following principles: (1) Health education should be a required part of primary and secondary education; (2) Private industry should be encouraged to provide preventive services and health education to employees; (3) All health care professions should be utilized for the delivery of preventive medicine services and health education; (4) Greater emphasis on preventive medicine should be incorporated into the curriculum of all health care professionals; (5) A sufficient number of training programs in preventive medicine and associated fields should be established, and adequate funding should be provided by government if private sources are not forthcoming; (6) Financing of medical care should be changed to include payment for preventive services and health education; (7) Appropriate legislation should be passed to protect the health of the population from behavioral and environmental risk factors, including, but not limited to, the following: (a) handgun control, (b) antismoking, (c) enforcement of drunk driving laws, (d) mandatory use of seat belts, (e) environmental protection laws, (f) occupational safety, and (g) toxic waste disposal; and 8) Preventive health services should be made available to all population segments, especially those at high risk. (MSS Rep C, I-82) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep C, A-04) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 50
(A-17)

Introduced by: Catherine Woodard, Hanna Chang, Monica Purmalek, Jeffrey Elliott, Bohan Liu, Matthew Nelson, Uniformed Services University of the Health Sciences; AJ Shadrach, Central Michigan University College of Medicine; Gabriel Pham, University of Cincinnati College of Medicine; Manna Varghese, University of Missouri-Kansas City

Subject: Opposition to Abuses of the Orphan Drug Act

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, In order to offset the high cost and lengthy FDA approval process for new drugs, the
2 Orphan Drug Act was passed in 1983 to incentivize and promote the development of new drugs
3 for rare diseases defined as those affecting fewer than 200,000 Americans¹; and
4
5 Whereas, The Orphan Drug Act provides financial incentives for the development of new drugs
6 for rare diseases by 1) giving research grants to help fund and promote medications used to
7 treat “orphan diseases,” or rare diseases, 2) providing a tax credit that covers half the cost of
8 clinical trials, and 3) granting the new drug exclusive marketing rights for seven years¹; and
9
10 Whereas, Though the incentives and monetary benefits offered by the federal government
11 through the Orphan Drug Act are designed to offset the cost of providing drug therapies for a
12 small market size, there is currently no way to distinguish between investment companies that
13 lack pharmaceutical expertise but are acquiring drug patents for the sole benefit of maximizing
14 profits, and well-intentioned pharmaceutical companies that are able to conduct proper research
15 and development or manufacturing for a therapeutic drug²; and
16
17 Whereas, Companies have benefited from the special incentives and tax breaks that the
18 Orphan Drug Act provides for what are currently common generic compounds instead of novel
19 therapeutic agents like the act was intended for³; and
20
21 Whereas, Murigenetics SAS benefited from the Orphan Drug Act in 2009 while seeking
22 approval for ascorbic acid as a treatment of Charcot-Marie-Tooth disease type 1A, thus a
23 common generic compound that was already approved as a vitamin was generously provided
24 with tax breaks under the act⁴ and
25
26 Whereas, R&D Laboratories, Inc. also benefited from the Orphan Drug Act when they sought
27 approval for calcium carbonate in 1990 as a treatment for hyperphosphatemia in patients with
28 end stage renal disease⁵; and
29
30 Whereas, These abuses of the Orphan Drug Act undermine the act’s initial purpose and
31 dissuade pharmaceutical companies from developing novel therapeutic compounds for rare
32 diseases as the act unfortunately makes it too simple to instead repurpose already profitable

1 drugs⁵; and

2

3 Whereas, The Orphan Drug Act, as currently written, fails to incentivize development of novel
4 therapeutic compounds, thus compromising patient care for those with rare diseases⁸; and

5

6 Whereas, Existing AMA-MSS policy asks the AMA to oppose abuses of the intent of the Orphan
7 Drug Act (100.002MSS), but it is critical that this policy be more specific; therefore be it

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9 RESOLVED, that our AMA-MSS amend policy 100.002MSS Opposition to Abuses of the
10 Orphan Drug Act by insertion and deletion as follows:

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100.002MSS Opposition to Abuses of the Orphan Drug Act:

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Our AMA-MSS will ask the AMA to opposes abuses of the intent of the Orphan Drug Act by (1) urging lawmakers to require that pharmaceutical companies demonstrate significant efforts to research and develop novel drugs for rare diseases so as to effectively advance therapeutics and provide the best quality treatment options for patients with rare diseases, and (2) supporting the requirement that companies receiving federal incentives or benefits under the Orphan Drug Act show evidence of participation in active and substantial research and development so as to reward those companies that aim to develop novel drugs rather than those seeking maximal profits at the expense of patient's financial resources, and (3) supporting legislation to discourage pharmaceutical companies from repurposing existing drugs, but rather supports legislation that encourages companies to make substantial efforts to develop novel drugs.

Fiscal note: TBD

Date received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

100.002MSS Opposition to Abuses of the Orphan Drug Act:

AMA-MSS will ask the AMA to oppose abuses of the intent of the Orphan Drug Act. (AMA Res 37, I-90 Referred) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Amended: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I15)

Pharmaceutical Cost H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients, and will report back to the House of Delegates regarding the progress of the drug pricing advocacy campaign at the 2016 Interim Meeting.

Reducing Prescription Drug Prices D-110.993

Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical

assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.

Cost of Prescription Drugs H-110.997

Our AMA:

- (1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;
- (2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;
- (3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;
- (4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;
- (5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;
- (6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and
- (7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

Cost of New Prescription Drugs H-110.998

Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 51
(A-17)

Introduced by: Daniel Ramon, Lauren Terpak, Nassier Harfouch, and Lauren Buckley,
University of South Florida Morsani College of Medicine

Subject: Expanding GME Funding Sources

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1 Whereas, A 2016 study by the Association of American Medical Colleges (AAMC) projects that
2 by 2025 an expected shortage of between 61,700 and 94,700 physicians is expected to occur in
3 the United States. Physician supply is a function of the number of physicians trained and
4 licensed to practice independently, which is accomplished through graduate medical education
5 (GME);^{1,2} and
6

7 Whereas, The 2016 National Resident Matching Program (NRMP), the application for GME, had
8 35,476 applicants for 30,750 positions in teaching hospitals, signifying a major incongruence
9 between number of applicants and GME positions: 93.8% of US allopathic medical students
10 obtained a first-year position in a teaching hospital, with lower match rates for osteopathic
11 medical students (80.3%) and international medical graduates (50.3%);³ and
12

13 Whereas, The largest source of GME funding comes from Medicare, estimated at \$11.3 billion
14 in 2013, through Direct Graduate Medical Education (DGME) payments and Indirect Medical
15 Education (IME) payments. The Balanced Budget Act of 1997 put a limit or “cap” on the number
16 of “full-time equivalent” residents that Medicare would fund, but many hospitals have used their
17 revenues to pay for additional GME positions;^{4,5} and
18

19 Whereas, The 2016 Medicare Trustees Report projects that by 2028 the Hospital Insurance
20 (Medicare Part A) trust fund will be depleted, affecting inpatient hospital care and funding for
21 GME. Currently, the remaining costs for GME are financed by other federal programs, state and
22 local governments, hospital revenues, and philanthropies;^{6,4} and
23

24 Whereas, AMA policy D-305.967 states that our AMA “recognizes that funding for and
25 distribution of positions for GME are in crisis in the United States and that meaningful and
26 comprehensive reform is urgently needed”; and
27

28 Whereas, A 2016 study found that 7.7% of internal medicine training sites at Medicare-funded
29 hospitals are private for-profit. The study also found that 7.9% of general surgery training sites
30 at Medicare-funded hospitals are private for-profit;⁷ and
31

32 Whereas, The for-profit Hospital Corporation of America (HCA) funds residency programs as a
33 way of recruiting physicians by hiring from their residents once they have finished training. In
34 2015, the HCA partnered with the University of Central Florida College of Medicine to sponsor
35 residency programs accredited by the ACGME;^{8,9} and
36

37 Whereas, Non-profit hospitals and medical schools are granted tax-exempt status by the
38 Internal Revenue Service (IRS). Therefore, non-profit hospitals and medical schools do not pay

1 taxes on GME funds, whereas for-profit hospitals and medical schools do have to pay taxes on
2 GME funds;¹⁰ and

3
4 Whereas, The American College of Phlebology (ACP) Foundation offers subsidies to programs
5 that offer a fellowship in Venous and Lymphatic Medicine. The American College of Phlebology
6 Foundation is also offering a fellowship in partnership with the Stony Brook School of Medicine
7 in New York;¹¹ and

8
9 Whereas, The American College of Medical Genetics and Genomics (ACMG) Foundation
10 currently funds an ACGME-accredited clinical genetics residency and laboratory biochemical
11 genetics fellowship training program. Both the ACMG and ACP have utilized their funds to
12 increase residency and fellowship positions in their respective fields;¹² and

13
14 Whereas, Private insurers reimburse 45% of all paid hospital days in the United States.
15 However, unlike Medicare IME payments, they do not compensate teaching hospitals for the
16 relatively higher operating costs that are attributable to the involvement of residents in patient
17 care, the complex patients they treat, and the highly specialized care teaching hospitals
18 provide;^{13,5} and

19
20 Whereas, Medicare DGME and IME payments are paid directly to the teaching hospitals. Since
21 teaching hospitals pay resident salaries, Medicare rules prohibit the direct billing of individual
22 services provided by residents as this would be construed as “double billing.” Therefore,
23 residents perform a significant number of unsupervised procedures on patients with private
24 insurance without charge;¹³ and

25
26 Whereas, A 2011 study found that this pro bono service represents \$232,726 of lost income per
27 hospital every year. Billing for these services would offset the costs of graduate medical
28 education;¹³ and

29
30 Whereas, The United States House of Representatives and United States Senate have both
31 introduced legislation to impose “specified fees on health insurance” to fund GME: the All-Payer
32 Graduate Medical Education Act of 2001 and the Medical Education Trust Fund Act of 2001;^{14,15}
33 therefore be it

34
35 RESOLVED, That our AMA advocate for legislation to create for-profit hospital and medical
36 school tax-sheltered funds for these organizations and programs to create additional residency
37 positions; and be it further

38
39 RESOLVED, That our AMA advocate for medical specialty association funding, in which these
40 associations allocate a portion of membership dues to create additional residency positions in
41 their respective specialties that they can use at their discretion; and be it further

42
43 RESOLVED, That our AMA advocate for federal legislation to pursue an assessment on health
44 insurance companies to supplement GME funding and consequently increase the number of
45 residency positions; and be it further

46
47 RESOLVED, That our AMA advocate for private funding, in which large employment companies
48 assign a portion of their revenue to fund residency programs; and be it further

49
50 RESOLVED, That our AMA advocate for legislation to acquire non-profit organization funding on
51 state or national levels for GME and consequently increase the number of residency positions.

Fiscal Note: TBD

Date Received: 04/20/2017

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RELEVANT AMA AND AMA-MSS POLICY:

Securing Funding for Graduate Medical Education. H-310.917

Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy D-305.958

1. Our AMA will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform.
2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US.
3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997.
4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages.
5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians.
6. Our AMA will work with key organizations, such as the US Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to: (A) support development of reports on the economic multiplier effect of each residency slot by geographic region and specialty; and (B) investigate the impact of GME funding on each state and its impact on that state's health care workforce and health outcomes.

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs. H-305.929

1. It is AMA policy that:
 - A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.
 - B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.
 - C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.
 - D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.
 - E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.

F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.

G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.

H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.

I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.

3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.

4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.

5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education. D-305.967

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).

2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.

3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to

occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.

15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.

16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.

17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.

18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will study the effect of medical school expansion that occurs without corresponding graduate medical education expansion.

Securing Medicare GME Funding for Research and Ambulatory Non-Hospital Based Outside Rotations During Residency D-305.963

Our AMA will: 1. Advocate for the Centers for Medicare and Medicaid Services (CMS) (both federal Medicare and federal/state Medicaid) funding for the time residents and fellows spend in research, didactic activities, and extramural educational activities required for the Accreditation Council for Graduate Medical Education (ACGME) accreditation during their training. 2. Continue to work with organizations such as the Association of American Medical Colleges (AAMC) and the Council on Graduate Medical Education (COGME), to make recommendations to change current Graduate Medical Education (GME) funding regulations during residency training, which currently limit funding for research, extramural educational opportunities, and flexible GME training programs and venues. 3. Monitor any public and/or private efforts to change the financing of medical services (health system reform) so as to advocate for adequate and appropriate funding of GME. 4. Advocate for funding for training physician researchers from sources in addition to CMS such as the National Institutes of Health, the Agency for Healthcare Research and Quality, the Veterans Administration, and other agencies.

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON MEDICAL EDUCATION

MSS CME Report A
A-17

Subject: Redefining Policy for Resident Duty-Hours Based on New Evidence, With
A Focus on Addressing Resident Wellness

Presented by: MSS Committee on Medical Education
R. Logan Jones, Chair; Nara Tashjian, Vice Chair

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

INTRODUCTION

At its 2016 Annual Meeting, the AMA-MSS Assembly referred for study MSS Resolution 21, "Redefining Policy for Resident Duty-Hours Based on New Evidence, With a Focus on Addressing Resident Wellness," which states the following:

RESOLVED, That our AMA-MSS revise existing policy 310.030MSS by insertion and deletion as follows:

310.030MSS Resident/Fellow Work and Learning Environment

AMA-MSS will ask the AMA to: (1) define resident duty hours as those scheduled hours associated with primary resident or fellowship responsibilities; (2) support a limit on resident duty hours of 84 hours per week averaged over a two-week period; (3) support ~~on-call activities no more frequent than every third night and there be~~ at least one consecutive 24 hour duty-free period day every seven days, both averaged over a two week period; (4) ~~support a standard workday limit for resident physicians of 12 hours, with patient care assignments exceeding 14 hours considered on-call activities;~~ (5) ~~support a limit on scheduled on-call assignments of 24 consecutive hours, with on-call assignments exceeding 24 consecutive hours ending before 30 hours, and the final 6 hours of this shift are for education, patient follow-up, and transfer of care, and new patients and/or continuity clinics must not be assigned to the resident during this 6-hour period;~~ (6) ~~support the inclusion of home call hours in the total number of weekly scheduled duty hours if the resident on call can routinely expect to get a less than 5 consecutive hours of sleep;~~(7) support a limit on assignments in high intensity settings of ~~12 scheduled hours with flexibility for sign-off activities;~~ (8) (4) support that limits on duty hours must not adversely impact the organized educational activities of the residency

program; ~~(9)~~ ask the Accreditation Council for Graduate Medical Education to establish new requirements for mandatory and protected education time in residency programs that constitutes no less than 10% of scheduled duty hours; ~~(10)~~ (5) support that scheduled time providing patient care services of limited or no educational value be minimized; ~~(11)~~ (6) ask the Joint Commission on the Accreditation of Hospital Organizations (JCAHO) to create new resident work condition standards that require institutions to provide minimum ancillary staffing levels (e.g. 24 hour phlebotomy, transport services, etc.) at institutions that train physicians; ~~(12)~~ (7) ask JCAHO to establish reporting mechanisms and sanctions that increase hospital accountability for violations of resident work condition standards; and ~~(13)~~ (8) support the AMA Council on Legislation as the coordinating body in the creation of legislative and regulatory options; and be it further

RESOLVED, That our AMA-MSS support the Accreditation Council on Graduate Medical Education (ACGME) and professional societies to conduct research to form the best duty hour policy for the residents in their respective specialties and support research to develop specialty-specific mechanisms in residency programs that (a) preserve educational quality, (b) prevent physician burnout, and (c) promote physician wellness.

Accordingly, your Governing Council (GC) referred this report to your MSS Committee on Medical Education (CME). Your CME performed an analysis of pertinent policies on resident duty hours so that the MSS could account for a broad scope of residency programs and acknowledge varied perspectives, including those outside of the AMA-MSS. This report begins with an historical context on the issue of resident duty hours. It then examines the recommended changes to MSS policy 310.030 from Resolution 21, A-16 and discusses pertinent implications for each of these recommendations. Each section contains a summary that recapitulates CME's reasoning for supporting or not supporting the proposals in Resolution 21. Your CME provides its own amendments to MSS policy 310.030MSS, the primary goal of which is to emphasize resident wellness, which is reflected in the Recommendations portion of this report.

BACKGROUND

i. The History of Duty Hour Standards

The first study on resident duty hours' effect on resident performance was done in 1971 comparing errors in reading a standardized ECG between post-call residents and their colleagues. The authors found post call first-year residents performed less well on reading a standardized electrocardiogram compared to rested colleagues, and exhibited negative mood.¹ Despite these early findings, scholarly analysis of the impact of long duty hours did not take hold until the death of Libby Zion in 1984.

¹ Friedman RC, Bigger JT, Kornfeld DS. The intern and sleep loss. N Engl J Med. 1971;285(4):201-203. doi:10.1056/NEJM197107222850405.

Zion was cared for by first- and second-year residents at a New York teaching hospital who administered meperidine and phenelzine at too close of intervals, triggering serotonin syndrome and, consequently, her death. This mistake was attributed to long resident work hours and fatigue. The grand jury at her trial ruled for a reform in resident education, specifically targeting resident hours and supervision.²

In response, the Bell commission was created to look into duty hours and released an 80-hour weekly limit and a maximum of 24 hour consecutive shift recommendations in 1987. Its reasoning for an 80-hr work week hinged on the idea that, "There are 168 hours in a week. It is reasonable for residents to work a 10-hour day for 5 days a week. It is humane for people to work every fourth night. If you subtract the 50-hour week . . . from 168 hours, you end up with 118 hours. If you then divide 118 by 4 (every fourth night), it equals 30. If you then add 50 to 30, that equals an 80-hour week."² Ultimately, New York incorporated this recommendation into its health code in 1989. New York remains the only state with legislation on the topic of Graduate Medical Education (GME) duty hours.

As a profession, medicine has always strived to be a self-governing profession when possible. In response to the Zion incident and subsequent enactment of resident duty hour legislation, the Accreditation Council for Graduate Medical Education (ACGME) has been the predominant entity that sets policy and enforces resident/fellow duty hours.

In 1988, the ACGME Task Force on Resident Hours and Supervision proposed new standards for accredited programs, which were ultimately enacted and enforced beginning in 1992. The policy set forth standards including: "1) one day in seven away from the hospital; 2) on-call duty in the hospital no more frequently than every third night; 3) adequate backup if sudden and unexpected patient care needs create resident fatigue sufficient to jeopardize patient care; and 4) institutional policies to ensure that all residents are adequately supervised, with reliable methods of communication between residents and supervising physicians. The Task Force also recommended that each Review Committee develop specialty-specific standards regarding the frequency of duty and on-call assignments for residents."³

In 2001, the ACGME authorized the formation of a Work Group on Resident Duty Hours and the Learning Environment, and charged it with the development of common standards for resident duty hours that would be applied to all GME training programs. Out of this work, the 2003 ACGME common program requirements were developed noting a need for more specialty specificity in duty hour restrictions as well as the need to add more restrictions to protect resident sleep. They maintained the 1990 duty hour restrictions and added additional clauses to: (1) Add 6 hour period post-call to create flexibility for education and continuity of care, (2) A 10% or maximum 88 hours duty restriction exception granted by a review committee, (3) the inclusion of internal moonlighting in the 80-hour work week, (4) A 10-hour time period between daily duty

² Bell BM. Reconsideration of the New York State laws rationalizing the supervision and the working conditions of residents. *Einstein J Biol Med.* 2003;20(1):36–40.

³ ACGME. History of Duty Hours. <http://www.acgme.org/What-We-Do/Accreditation/Clinical-Experience-and-Education-formerly-Duty-Hours/History-of-Duty-Hours>. Accessed April 4, 2017.

periods and after in-house call, and (5) A maximum of in-house call every third night. They also permitted specialties such as Emergency Medicine and Anesthesiology to create and maintain personalized requirements to maximize patient quality of care. After implementation, studies found that on average residents were less fatigued, had increased well-being, and felt like they had more of a work-life balance. Residents were also found to work with increased intensity during with the hour restrictions.⁴ Representation from high duty-hour residencies, like surgery, expressed concern that the shift compromised residents' education. Critics believed that the duty hour restrictions lead to fragmentation and reduced continuity of care. National studies found little change in patient mortality rates.

In 2009 an ACGME task force was created to discuss and research new requirements for duty hours. The task force found that while quality of care previously was a concern, it had been unaffected after 2003 limits were instilled. They also surveyed residents who reported that the ideal duty hours for experiential learning hovered around 76-82.⁵ Studies also found that the duty hour restrictions led to an increase in the intensity of work done in their restricted time. The task force also found that PGY-1 residents make more errors when working longer hours demonstrating a need to stratify duty hour restrictions between residents.⁶

The ACGME released its revised common program requirements in 2011. Key features of these requirements included: (1) Keeping the 80 hour duty limit averaged for a 4-week period, inclusive of in-house call and moonlighting activities, (2) A 10% or maximum 88 hours duty restriction exception granted by a review committee, (3) Mandatory 1 day free every week averaged over four weeks, (4) Duty hour restrictions of 16 hours for PGY-1 residents, (5) 10 hours free between duty periods for PGY-1 residents, (6) No more than six consecutive nights of night float, (7) A maximum of in-house call every third night, and (8) The inclusion of at-home call in the 80 duty hour restriction.

On July 1st 2017, the ACGME will implement a new set of duty hour standards. Differing from previous iterations, the task force assigned to draft the new common program requirements was instructed to do so with a specific focus on implementing rules that would bolster patient safety, resident wellness, and quality improvement. The ACGME underwent an open-comment period in late 2016 in which they heard from student, resident, physician groups, patient advocacy organizations, and other stakeholders surrounding the conversation of the graduate medical education work/learning environment, including the AMA. Some of the largest changes to be implemented starting July 1, 2017, include: 1) removing the 16-hour cap for PGY-1 shifts, with the intent to re-establish team dynamics among interns and supervising residents 2) defined expectation that programs are to be held accountable on their efforts to support education by creating a more inclusive and supportive "learning and work environment" to improve safety,

⁴ Weinstein DF. Duty hours for resident physicians--tough choices for teaching hospitals. *N Engl J Med.* 2002;347(16):1275-1278. doi:10.1056/NEJMs022065.

⁵ Philibert I, Amis S. The ACGME 2011 Duty Hour Standards: Enhancing Quality of Care, Supervision, and Resident Professional Development. 2011. [https://www.acgme.org/Portals/0/PDFs/jgme-monograph\[1\].pdf](https://www.acgme.org/Portals/0/PDFs/jgme-monograph[1].pdf). Accessed April 4, 2017.

⁶ Lockley SW, Cronin JW, Evans EE, et al. Effect of reducing interns' weekly work hours on sleep and attentional failures. *N Engl J Med.* 2004;351(18):1829-1837.

quality, professionalism, and wellness; 3) requiring that clinical work done from home, including home call, be included in total duty hour counts; and 4) creating mechanisms to allow residents flexibility to stay beyond scheduled shifts if deemed necessary by the resident for reasons related to continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family *and* that this must occur within the context of the 80- hour and the one-day-off-in-seven requirements.

ii. AMA's Stance on Duty Hours

In 2014, the AMA House of Delegates restructured its policy on Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training. These changes are reflected in the recommendations put forth by the AMA Council on Medical Education in CME Rep 5, A-14.

Your MSS CME highly recommends MSS members refer to CME Report 5, A-14 for further information on the general stances of the AMA on resident/fellow work hours. Existing AMA policy on resident/fellow duty hours is housed under [AMA Duty Hours Policy H-310.907](#).

DISCUSSION OF PROPOSED CHANGES BY MSS RESOLUTION 21, A-16

1. *Do not adopt proposed removal of AMA-MSS support for on-call activities no more frequent than every third night. (310.030MSS Clause 3)*

The origins of limiting overnight in-house call to no more often than every third night (averaged over a four week period) arose from the ACGME 1987 Task Force on Resident Hours and Supervision and became part of the ACGME general program requirements in 1992.⁵ Since that time, the ACGME has maintained this position in every iteration of the core program requirements that all specialties must abide by in order to maintain accreditation. Current RFS and HOD policy concur with this ACGME standard.

As this policy has long remained entrenched in the standards of residency programs, all available literature on residency duty hours in recent years upholds this as a requirement, even during studies. One of the largest duty hour studies to date was published in the New England Journal in 2016. It was called the Flexibility in Duty Hour Requirements for Surgical Trainees (FIRST) trial.⁷ FIRST was designed to determine if removing program requirements for maximum shift length and minimum time off between shifts among general surgery programs would adversely affect patient outcomes, and secondarily how it impacted trainee wellness and education. Despite ethical concerns surrounding the trial design and implementation,⁸ the study design still upheld the requirement of call no more frequently than every third night. The importance of this is that nearly all evidence surrounding duty hours upholds this standard, and to seek repeal of this standard would be to go against the current body of evidence on this topic.

⁷ Bilimoria KY, Chung JW, Hedges LV, et al. National Cluster-Randomized Trial of Duty-Hour Flexibility in Surgical Training. *N Engl J Med*. 2016;374(8):713-727. doi:10.1056/NEJMoa1515724.

⁸ The Unethical iCOMPARE and FIRST Trials. Public Citizen.

<http://www.citizen.org/documents/PublicCitizenFactsheet-iCompareFIRST.pdf>. Published May 2016. Accessed April 4, 2017.

SUMMARY

Thus, as a general safeguard to the wellbeing of our trainees and to the protection of our patients, we believe that it is imperative to maintain well-prescribed limitations of in-house call frequency. Moreover, your CME solicited feedback from the AMA-RFS whose members encouraged the MSS to consider adopting language that would mirror other AMA sections and the ACGME policy. In response, your CME recommends amending MSS policy to average duty hours over a four-week period, instead of a two-week period.

2. *Adopt the proposed removal of AMA-MSS support for standard work day limit for resident physicians of 12 hours, with patient care assignments exceeding 14 hours considered on-call activities. (310.030MSS Clause 4)*

The origin of the term medical resident is from the historical model of graduate medical education, in which trainees would often maintain their domicile at their training institution. Hence, as they lived at the hospital, they were referred to as residents. In recent years, our European counterparts have sought to shift away from this model of condensed training. In 1998 the European Working Time Directive (EWTD) became law and imposed boundaries to resident training hours to include such things as a maximum of 48 hours per week and a minimum of 24 hours off per 7-day period. However, due to the difficulty meeting the medical care demands of society, only 6 of the 27 European member states meet the prescribed standard, some 14 years after the EWTD became a legal requirement.⁹

In the U.S., the proposal to move towards more modest shift lengths has likewise been met with concerns. The ACGME studied the implications of moving toward 16 consecutive hour limits for all residents, and it concluded, “[16-hour shift limits are] incompatible with the actual practice of medicine and surgery in many specialties, excessively limiting in configuration of clinical services in many disciplines, and potentially disruptive of the inculcation of responsibility and professional commitment to altruism and placing the needs of patients above those of the physician.”¹⁰ While some specialties were able to demonstrate small pilots to support 16-hour shift models, your CME did not find compelling evidence to support a wholesale transition to 16-hour shift maximums for all medical specialty training programs.

Shift work has been explored by other resident stakeholder groups as well. A 2016 position paper by the Committee of Interns and Residents (CIR), a group representing 14,000 U.S. interns, residents, and fellows, noted that exemplars do exist that demonstrate best-practice in how to incorporate shift work and night float systems in which trainees work up to 14 hours continuously. However, the group recognized that this model may not meet the demands and

⁹ Temple J. Resident duty hours around the globe: where are we now? BMC Med Educ. 2014;14(1):S8. doi:10.1186/1472-6920-14-S1-S8.

¹⁰ ACGME Common Program Requirements – Section VI Summary and Impact of Major Requirement Revisions. ACGME. http://www.acgme.org/Portals/0/PFAssets/ReviewandComment/CPR_SectionVI_ImpactStatement.pdf. Accessed March 31, 2017.

flexibility requirements for all specialty programs. Ultimately, rather than moving to abolish 24+4 hour shift, it proposed that programs be required to undergo continuous quality improvement (i.e. Plan, Do, Study, Act (PDSA) cycles) to engage in work and learning redesign to maximize patient safety and resident learning and wellbeing. It also ask for more transparency in the duty hour reporting process in hopes that outside stakeholders (i.e. fourth-year medical students) are more aware of the ongoing process.¹¹

SUMMARY

In order to apply this policy across all types of medical specialties and as the concern for its impact in the current state of medical practice in the United States today grows, your CME believes continued support for a standard 12-hours workday limit for residents would lead to undue negative consequences upon the educational pursuits of trainees and the health of our patients.

- 3. Do not adopt proposed amendment by deletion of AMA-MSS support for a limit on scheduled on-call assignments of 24 consecutive hours, with on-call assignments exceeding 24 consecutive hours ending before 30 hours, and the final 6 hours of this shift are for education, patient follow-up, and transfer of care, and new patients and/or continuity clinics must not be assigned to the resident during this 6-hour period. (310.030MSS Clause 5)*

As has been previously stated, prescribing a 12-hour maximum shift length to all residency programs could lead to instability within the healthcare system and possibly yield negative educational outcomes for trainees. However, this does not make the inverse true, namely, that extremely long shifts would be a panacea for this problem.

Overall, it is difficult to accurately assess the direct impact of the behavioral and environmental interventions embodied by duty hour policies. The FIRST trial, which allowed programs to schedule residents for shifts >28 hours and allowed them not to have minimum times off between shifts, demonstrated non-inferiority with respect to their primary outcomes of American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) composite outcome measure of the 30-day rate of postoperative death or serious complications.⁷ While this may indicate that patient outcomes are not affected by longer shifts, there is concern that that the intervention arm did not actually differ than the control arm in actual implementation. Moreover, the authors implicated that concerns for accurate duty hour logging could have played a large confounding role in the outcomes of the trial.¹² Ultimately, while the FIRST trial indicates that patient outcomes were non-inferior in the study group, your CME has concerns with the limitations of this study and the generalizability of the trial conclusions.

¹¹ Position Paper - Committee of Interns and Residents. In: ; 2016. <https://www.acgme.org/Portals/0/PDFs/Position%20Papers/Committee%20of%20Interns%20and%20Residents.pdf>. Accessed March 31, 2017.

¹² Bilimoria KY, Chung JW, Hedges LV, et al. Surgical resident duty hours. N Engl J Med. 2016;2016(374):2399–2403.

A large body of work has grown around the negative impact of sleep deprivation in medicine - with particular emphasis on post call effects.¹ These negative effects decreased resident performance on standardized exams, with one study correlating the loss to the difference between a first year and third year resident's performance on a standardized exam.¹³ These outcomes have also been upheld by more recent research.¹⁴ Furthermore, studies have found that residents experience the negative effects of call even after a full period of sleep.¹⁵ Several single center studies found that residents working traditional on-call schedules had six times more serious diagnostic errors and 36% more serious medical errors than residents working on a schedule that limited continuous duty to 16 hours.¹⁶

In addition to the potential dangers long shifts pose to patients, longer shifts have been implicated in adverse health consequences in trainees. Fatigue in the GME setting has been linked to higher rates of exposure to injury, including exposure to bodily fluids and percutaneous injuries. It has also been found that resident exposure to blood borne pathogens varied during a 24-hour period and raters were highest overnight. Resident who are fatigued also have much greater risks of falling asleep behind the wheel of a car and have been shown to experience more car crashes than non-residents. Additional epidemiological studies imply that sleep deprivation is also linked to additional health factors such as burnout, depression, weight gain, and diabetes.¹⁷

On the issue of learner satisfaction and wellness, secondary outcomes of the FIRST trial demonstrated that residents in the control arm were dissatisfied with the restrictive duty hours policy and cited them as a direct cause of: having missed or left an operation, decreased perception of ability to acquire clinical/surgical skills, ability to attend educational sessions, and perceived loss of continuity of care and patient safety. On the other side of the coin however, the control group was more likely to have better health, rest, time with friends/family, and time for research and extracurricular activities. Overall, many primary discussions with our resident/fellow colleagues would echo the sentiments on duty hours reported in the FIRST trial data.

¹³ Jacques CH, Lynch JC, Samkoff JS. The effects of sleep loss on cognitive performance of resident physicians. *J Fam Pract.* 1990;30(2):223-229.

¹⁴ Arora VM, Georgitis E, Siddique J, et al. Association of workload of on-call medical interns with on-call sleep duration, shift duration, and participation in educational activities. *JAMA.* 2008;300(10):1146-1153. doi:10.1001/jama.300.10.1146.

¹⁵ Arendt J. Shift work: coping with the biological clock. *Occup Med Oxf Engl.* 2010;60(1):10-20. doi:10.1093/occmed/kqp162.

¹⁶ Lockley SW, Landrigan CP, Barger LK, Czeisler CA, Harvard Work Hours Health and Safety Group. When policy meets physiology: the challenge of reducing resident work hours. *Clin Orthop.* 2006;449:116-127. doi:10.1097/01.blo.0000224057.32367.84.

¹⁷ Safety I of M (US) C on OGMT (Resident) H and WS to IP, Ulmer C, Wolman DM, Johns MME. *Impact of Duty Hours on Resident Well-Being.* National Academies Press (US); 2009. <https://www.ncbi.nlm.nih.gov/books/NBK214939/>. Accessed April 4, 2017.

Taking all of this into account, your CME acknowledges that there is no perfect solution to the problem of GME duty hours.¹⁸ Thus, the best the profession can do is to move forward and iteratively seek to promote trainee wellness, a tailored education by specialty and improve the quality of care for patients. To do so requires training programs to be flexible and explore ways to achieve these ends. Nevertheless, this does not mean that reasonable and rational limitations must be abandoned in the name of flexibility.

SUMMARY

Your CME does not recommend the removal of support for maximum shift lengths of 24 hours. Moreover, your CME posits that the MSS should seek to reduce the current maximum shift length of 30 hours (24+6) to align with current AMA policy to have maximum shift lengths of 28 (24+4) hours; 24 hours for patient care with the last four hours reserved for handoff and education. Finally, acknowledging that inflexibility of duty hours has historically caused distress among resident trainees, your CME recommends inclusion of language to allow flexibility for residents to stay beyond their scheduled 28-hour limit to provide care for a single patient when important for patient care, educational, or humanistic needs.

- 4. Do not adopt amendment by deletion of AMA-MSS support for the inclusion of home call hours in the total number of weekly scheduled duty hours if the resident on call can routinely expect to get a less than 5 consecutive hours of sleep. (310.030MSS clause 6)*

As the 80-hr work week was implemented, residents in time-intensive specialties experienced an increase in the amount of home call hours in order to comply with duty hour restrictions. Multiple residencies, especially surgical specialties, saw an increase in home call.^{19,20} One notable study observed a 33% increase in home call for interns in a cross-sectional survey of ENT residents.²¹ These findings suggest that residencies were not decreasing workload, but instead re-assigning it.

This increase in home call has resulted in an increase in post call fatigue. A recent study found that post call sleep deprivation was correlated with the number of calls taken after midnight. Furthermore, this study found that the location, home or in-hospital, had no effect on sleep deprivation.²² This study demonstrates the negative impact night call can have on sleep. By

¹⁸ Camillus JC. Strategy as a Wicked Problem. Harvard Business Review.

<https://hbr.org/2008/05/strategy-as-a-wicked-problem>. Published May 1, 2008. Accessed April 1, 2017.

¹⁹ Landrigan CP, Rothschild JM, Cronin JW, et al. Effect of Reducing Interns' Work Hours on Serious Medical Errors in Intensive Care Units. N Engl J Med. 2004;351(18):1838-1848. doi:10.1056/NEJMoa041406.

²⁰ Kusuma SK, Mehta S, Sirkin M, et al. Measuring the attitudes and impact of the eighty-hour workweek rules on orthopaedic surgery residents. J Bone Joint Surg Am. 2007;89(3):679-685. doi:10.2106/JBJS.F.00526.

²¹ Brunworth JD, Sindwani R. Impact of duty hour restrictions on otolaryngology training: divergent resident and faculty perspectives. The Laryngoscope. 2006;116(7):1127-1130. doi:10.1097/01.mlg.0000224348.44616.fb.

²² Caulley L, Quimby AE, Barrowman N, Moreau K, Vaccani J-P. Effect of Home-Call on Otolaryngology Resident Education: A Pilot Study. J Surg Educ. 2017;74(2):228-236. doi:10.1016/j.jsurg.2016.08.019.

shifting work to home in order to save duty hours, residents are burning the candle at both ends. They are experiencing the negative effects of sleep deprivation that the duty hour restrictions seek to protect.

SUMMARY

The 2017 ACGME observed this shift and consequently it has stricken from its standards the five consecutive hours of sleep from the policy to include all home call in the 80-hr work week. The RFS and HOD policy also currently uphold this standard. For these reasons, we believe that in order to protect resident duty hours, home call should be included in scheduled duty hours regardless of sleep obtained.

5. *Adopt in part amendment by deletion of AMA-MSS support for a limit on assignments in high intensity settings of 12 scheduled hours with flexibility for sign off activities. (310.030MSS Clause 7)*

The context surrounding “high intensity” work usually is focused on work in the Emergency department. As part of New York State regulations that were drafted in relation to the Libby Zion incident, the law currently specifies that residents working in an emergency setting are only allowed to work 12-continuous hours and are allotted 3 additional hours for transition of care. While the ACGME core program requirements do not specifically stipulate or define what constitutes high intensity settings, the ACGME Emergency Medicine program requirements do explicitly state that continuous shifts should not be longer than 12 hours.

Although Emergency medicine work is often cited as the standard of high intensity work, it is unclear what other practice domains may fall under this nomenclature. A 2003 AAMC policy paper on GME also included the ICU included in “high intensity” work, as does the Sleep research Society.^{23,24} Our current AMA-MSS (310.030MSS) and AMA-RFS (310.579R) policy also considers ICU work alongside shifts in the emergency department as high intensity work. Beyond this however, a literature search did not provide a universally accepted definition of what constitutes high intensity work within GME.

SUMMARY

Without agreed upon standard language for all parties to use in defining high intensity work, there is concern that the status of the current AMA-MSS policy is overly vague and without meaningful direction. As has been discussed, flexibility among individual specialties to determine if certain practice settings require additional regulation should be left as an issue of

²³ AAMC Policy Guidance on Graduate Medical Education: Assuring... : Academic Medicine. LWW. http://mobile.journals.lww.com/academicmedicine/Fulltext/2003/01000/AAMC_Policy_Guidance_on_Graduate_Medical.22.aspx. Accessed April 1, 2017.

²⁴ Resident Work Hours - Past SRS Government Relations Initiative. <http://www.sleepresearchsociety.org/residentworkhours.aspx>. Accessed April 1, 2017.

self-governance. Thus, at this point, we agree with removal of language that specifically limits shift duration in “high intensity settings.”

6. *Do not adopt amendment by deletion of AMA-MSS support for the involvement of the Accreditation Council for Graduate Medical Education in establishing new requirements for mandatory and protected education time in residency programs that constitutes no less than 10% of scheduled duty hours. (310.030MSS clause 9)*

In its 2017 guidelines, the ACGME recognized that the learning objective of residency programs should “be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events.” While time spent doing didactic educational events are easily tabulated, the previous two methodologies are much more evasive to calculate. Not all learning comes from a didactic and protected format.

Furthermore, a study implemented after duty hour restrictions that polled internal medicine residencies in the US found that the mean weekly change in educational hours before and after implementation did not change significantly. It did find, however, that the intern attendance did decrease. Yes, their education was affected, but simple hour calculation of the educational activities hours did not demonstrate this shift.²⁵

As pointed out by the ACGME, not all learning takes place in a didactic format. A study of internal medicine residents found little efficacy on a lecture format on long-term knowledge retention and testing performance. It instead emphasized the need for flexibility or learning as well as the benefits of team-based learning and overall improvement of resident satisfaction and learning.²⁶

Due to the different styles of learning and the benefits of different types of learning in resident education, setting aside a certain percent of protected time becomes too exclusive. We believe that instead of spending time determining what aspects of a resident’s career are considered educational, an emphasis should be placed to instead decrease residents’ non-clinical obligations. These non-physician obligations include tasks that are traditionally performed by nursing, other health professionals, transport services, or clerical staff.¹⁰ This policy is also reflected in RFS and AMA policy.

SUMMARY

For these reasons, your CME believes that residency programs can maximize learning objectives, in part by driving down non-physician obligations, to ensure educational

²⁵ Horwitz LI, Krumholz HM, Huot SJ, Green ML. Internal medicine residents’ clinical and didactic experiences after work hour regulation: a survey of chief residents. *J Gen Intern Med.* 2006;21(9):961-965. doi:10.1111/j.1525-1497.2006.00508.x.

²⁶ Sawatsky AP, Zickmund SL, Berlacher K, Lesky D, Granieri R. Understanding resident learning preferences within an internal medicine noon conference lecture series: a qualitative study. *J Grad Med Educ.* 2014;6(1):32-38. doi:10.4300/JGME-06-01-37.1.

opportunities for their residents all without being held accountable to pre-specified protected hour format.

7. *Nature of AMA-MSS policy 310.030MSS*

Your CME found it appropriate to retain this resolution as internal MSS policy, as a primary function of this report was to update current MSS policy rather than update AMA policy. Indeed, your CME felt it important to mirror AMA and RFS policy on resident duty hours in its recommendations.

OTHER POLICY CONSIDERATIONS

1. *AMA-MSS definition of resident duty hours (310.030MSS Clause 1)*

Your CME felt that existing definition of resident duty hours under MSS policy 310.030, which defines them as scheduled hours associated with primary resident or fellowship responsibilities, fails to meet the current state of residency duty hours given the recent changes by ACGME and for reasons stated above. The ACGME cites the inclusion of “all in-house clinical and educational activities, clinical work done from home, and moonlighting” in its policy.¹⁰ We feel that this addition best encompasses all activities included in the duty hour restriction.

SUMMARY

Your CME recommends that duty hours be defined as clinical and educational activities, clinical work done from home, and all moonlighting to best include above recommendations.

2. *AMA-MSS support for a limit on resident duty hours of 84 hours per week averaged over a two-week period (310.030MSS clause 2)*

Current AMA policy upholds an 80-hour work week averaged over a four-week period. This is also found in ACGME and RFS policy. As previously cited above, the 80-hour work week was first evoked by the Bell Commission in 1987 and has been the common working benchmark for duty hour caps found in policy and writings on duty hours policy for over 15 years. The AMA-MSS would benefit from aligning its current policy to adopt this common language. Furthermore, reducing the allowable work hours from 84 to 80 is in line with the primary focus of this policy update to pursue the intent of resident/fellow wellness. Finally, feedback from the AMA-RFS was solicited, which encouraged the MSS to consider adopting language that would mirror other AMA sections and the ACGME policy at this time.

SUMMARY

Your CME recommends the AMA-MSS support an 80-hour work week averaged over a four-week period. Such policy aligns with current AMA, RFS, and ACGME policy.

3. *AMA-MSS support on-call activities no more frequent than every third night and there be at least one consecutive 24 hour duty-free period day every seven days, both averaged over a two week period (310.030MSS clause 3)*

Existing AMA, RFS, and ACGME policy supports one consecutive 24 hour duty-free period day every seven days, averaged over a *four* week period. Finally, feedback from the AMA-RFS was solicited, which encouraged the MSS to consider adopting language that would mirror other AMA sections and the ACGME policy at this time.

SUMMARY

Your CME recommends the adoption of the four-week period instead of the two-week period to comply with AMA policy, RFS policy, and ACGME policy.

4. *The Joint Commission and ACGME Monitoring (310.030MSS clauses 11-13)*

To update this policy, there is a foundational philosophy which the AMA-MSS must first consider as it decides how to proceed with this policy. These subsections effectively are countercurrent to current HOD policy, and moreover and countercurrent to the foundational identity of a profession. Current AMA HOD policy states, ““The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of duty hour regulations, and opposes any regulatory or legislative proposals to limit the duty hours of practicing physicians.” (AMA Duty Hours Policy H-310.907) In correspondence with leadership in the AMA-RFS, it was also discussed that this policy may no longer be the appropriate or desired course of strategic action from the perspective of the AMA-RFS. Thus, our AMA-MSS must grapple with how to approach this question.

To contextualize, when 301.030MSS was adopted in 2002, this predated the implementation of the 2003 AGCME common program requirements which drastically changed the conversation on resident duty hours. The prevailing sentiment among residents at that time was such that they often felt disempowered to report and voice concerns on duty hours. The policy of pursuing the option for external entities to penalize hospitals associated with training programs was to allow an alternative conduit by which residents could improve their working conditions without risking personal retribution or putting their own training program at risk during reaccreditation.

While resident duty hours are objectively better now as compared to 2002, it is still not uncommon for residents to have to inaccurately report their duty hours ¹². Even though the ACGME is now much more responsive and attuned to monitoring duty hours and intervene on

infractions of policy, residents still find themselves in a sort of prisoner's dilemma of feeling free to openly report their duty hours in actuality. Thus, the question of how the AMA-MSS should approach this policy of encouraging external entities such as the Joint Commission to monitor and enforce duty hours requires much debate.

Nonetheless, our current policy does require updating as the language found currently in 310.030MSS is outdated and regardless of how the AMA-MSS handles this policy in the future, for now it should be updated to reflect new terminology in that the Joint Commission on the Accreditation of Hospital Organizations (JCAHO) is now only referred to as The Joint Commission.

SUMMARY

Your CME found it prudent to update the title of the Joint Commission to reflect its current designation. Your CME found it worthwhile for our AMA-MSS to study the assertions made in 11-13 as previously discussed, the context surrounding the issue of professional self-governance in duty hours has evolved since the adoption of the parent policy in 2002.

RECOMMENDATIONS

- 1) That the AMA-MSS amend existing policy 310.030 by addition and deletion to read as follows:

310.030MSS Resident/Fellow Work and Learning Environment

The AMA-MSS will ask the AMA to supports the following general principles regarding resident/fellow duty hours to promote physician wellness: (1) Duty hours shall be defined as clinical and educational activities, clinical work done from home, and all moonlighting; define resident duty hours as those scheduled hours associated with primary resident or fellowship responsibilities; (2) The total number of duty hours should not exceed 80 hours when averaged over a four-week period; support a limit on resident duty hours of 84 hours per week averaged over a two-week period; (3) Trainees must be scheduled for in-house call no more frequently than every-third-night, averaged over a four-week period; support on-call activities no more frequent than every third night and there be at least one consecutive 24 hour duty free period day every seven days, both averaged over a two-week period; (4) Scheduled on-call assignments should not exceed 28 hours, with the last 4 hours being reserved for education, patient follow-up, and transfer of care; support a standard workday limit for resident physicians of 12 hours, with patient care assignments exceeding 14 hours considered on-call activities; (5) Limits on duty hours must not adversely impact the organized educational activities of the residency program; support a limit on scheduled on-call assignments of 24 consecutive hours, with on-call assignments exceeding 24 consecutive hours ending before 30 hours, and the final 6 hours of this shift are for education, patient follow-up, and transfer of care, and new patients and/or continuity clinics must not be assigned to the resident during this 6-hour

~~period; (6) Scheduled time providing patient care services of limited or no educational value should be minimized; support the inclusion of home call hours in the total number of weekly scheduled duty hours if the resident on call can routinely expect to get a less than 5 consecutive hours of sleep;(7) Trainees must have at least one consecutive 24 hour duty-free period day every seven days, averaged over a four-week period; support a limit on assignments in high intensity settings of 12 scheduled hours with flexibility for sign off activities;(8) Flexibility for residents to stay beyond their scheduled 28 hour limit to provide care for a single patient when important for patient care, educational, or humanistic needs, and that these hours count towards the weekly 80 hour limitation; support that limits on duty hours must not adversely impact the organized educational activities of the residency program;(9) ask the Joint Commission to create new resident work condition standards that require institutions to provide minimum ancillary staffing levels (e.g. 24 hour phlebotomy, transport services, etc.) at institutions that train physicians; ask the Accreditation Council for Graduate Medical Education to establish new requirements for mandatory and protected education time in residency programs that constitutes no less than 10% of scheduled duty hours; (10) ask the Joint Commission to establish reporting mechanisms and sanctions that increase hospital accountability for violations of resident work condition standards; and ~~support that scheduled time providing patient care services of limited or no educational value be minimized;~~ (11) Support the AMA Council on Legislation as the coordinating body in the creation of legislative and regulatory options. ask the Joint Commission on the Accreditation of Hospital Organizations (JCAHO) to create new resident work condition standards that require institutions to provide minimum ancillary staffing levels (e.g. 24 hour phlebotomy, transport services, etc.) at institutions that train physicians; (12) ~~(7)~~ ask JCAHO to establish reporting mechanisms and sanctions that increase hospital accountability for violations of resident work condition standards; and ~~(13) (8)~~ support the AMA Council on Legislation as the coordinating body in the creation of legislative and regulatory options; and be it further~~

- 2) That our AMA-MSS study clauses 9 through 11 of amended MSS policy 310.030 and to assess the need for the MSS' continued support.
- 3) That the remainder of this report be filed.

A clean version of your CME's proposed amendments follows.

310.030MSS Resident/Fellow Work and Learning Environment

The AMA-MSS supports the following general principles regarding resident/fellow duty hours to promote physician wellness: (1) Duty hours shall be defined as clinical and educational activities, clinical work done from home, and all moonlighting; (2) The total number of duty hours should not exceed 80 hours when averaged over a four-week period; (3) Trainees must be scheduled for in-house call no more frequently than every-third-night, averaged over a four-week period; (4) Scheduled on-call assignments should

not exceed 28 hours, with the last 4 hours being reserved for education, patient follow-up, and transfer of care; (5) limits on duty hours must not adversely impact the organized educational activities of the residency program (6) Scheduled time providing patient care services of limited or no educational value should be minimized; (7) Trainees must have at least one consecutive 24 hour duty-free period day every seven days, averaged over a four-week period; (8) Flexibility for residents to stay beyond their scheduled 28 hour limit to provide care for a single patient when important for patient care, educational, or humanistic needs, and that these hours count towards the weekly 80 hour limitation; (9) ask the Joint Commission to create new resident work condition standards that require institutions to provide minimum ancillary staffing levels (e.g. 24 hour phlebotomy, transport services, etc.) at institutions that train physicians; (10) ask the Joint Commission to establish reporting mechanisms and sanctions that increase hospital accountability for violations of resident work condition standards; and (11) support the AMA Council on Legislation as the coordinating body in the creation of legislative and regulatory options.

ACKNOWLEDGEMENTS

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON LONG RANGE PLANNING

COLRP Report A
A-17

Subject: Reevaluation of AMA-MSS Region Bylaws

Presented by: Rajita Kumar, Chair; Steven Ekman, Vice Chair
MSS Committee on Long Range Planning

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

INTRODUCTION

At the 2015 Annual Meeting, the AMA-MSS adopted AMA-MSS Governing Council Report D, A-15 "Evaluation of AMA-MSS Region Bylaws," which recommended the following:

- 1) That all Medical Student Region Bylaws include, at minimum, abbreviated versions of:
 - a. The purpose of the Medical Student Region to elect Regional Delegates to the AMA House of Delegates per MSS IOP VIII. A;
 - b. The responsibilities of the Region Chair per MSS IOP VIII. A. 3;
 - c. An outline of the requirements for Regional Delegate Elections per MSS IOP VIII. B.2;
 - d. Descriptions of their Regional Governing Council per MSS IOP VIII. A.4; and
 - e. Determination and Responsibilities of the Regional Delegate Chair per MSS IOP VIII.C.
- 2) That all Medical Student Region Bylaws are in accordance with the prevailing parliamentary code of our AMA per MSS IOP XII.A;
- 3) That the Speaker or Vice Speaker or his or her designee be authorized to correct article and section designations, punctuation and cross-references, and to make such other technical and conforming changes as may be necessary to reflect the intent of the MSS with respect to the Medical Student Region bylaws requirements as recommended by this report; and
- 4) That our AMA-MSS reevaluate the content of each Medical Student Region's bylaws and report back by A-17.

The main purpose of this report is to reevaluate each of the seven Region's bylaws in an effort to increase transparency so that each Region can understand the governing processes of other regions.

This report highlights the similarities and differences in the Region bylaws in the following categories: quorum, voting, and parliamentary procedure. In addition, this report assesses each region's adherence to the minimum bylaw requirements outlined in the AMA-MSS GC Report D,

A-15, "Evaluation of AMA-MSS Region Bylaws." Additionally, there is an interest among MSS members and region leadership to clarify and enumerate the process by which Regions elect to author a resolution. Thus, this report also lays out each region's resolution authorship process.

METHODS

The most current bylaws adopted by each region were submitted to your Committee on Long Range Planning (COLRP) in January 2017. Your COLRP acknowledges that some Regions may have updated their by-laws after January 2017 and that this report may not reflect those updates. COLRP assessed the inclusion of minimum bylaws based on the AMA-MSS GC Report D, A-15, "Evaluation of AMA-MSS Region Bylaws" as outlined in Table 1 and outlined each region's process for quorum, voting, parliamentary procedures, and resolution authorship.

RESULTS

i. Recommended Region bylaw provisions pursuant to GC Report D, A-15

Table 1 outlines each Region's inclusion of the minimum bylaws as recommended by AMA-MSS GC Report D, A-15. Regions 1, 2, 3, and 5 include a clause stating that the purpose of the Medical Student Region is to elect Regional Delegates to the HOD. All seven regions delineate in their bylaws the responsibilities of the Region Chair. Similarly, all seven Regions include bylaws that describe the requirements for Regional Delegate elections. Regions 1, 3, 5, 6, and 7 bylaws outline descriptions of their Regional Governing Council. In addition, Regions 1, 2, 5, and 7 specifically detail how to determine the Regional Delegate Chair. Regions 1, 2, and 5 bylaws describe the responsibilities of their Regional Delegate Chair.

ii. Quorum/Voting

Table 2 outlines each region's specific criteria for establishing quorum. Each Region's bylaws include specific language that determine the number of votes each school in a region will receive as shown in Table 3. Regions 3, 4, 6 and 7 define quorum as one-third of total chapters with a minimum of 3 states in that region. Region 1 only requires one-third of all the chapters to be present without restrictions on state. Regions 2 and 5 require half of all chapters to be present for a minimum of 4 and 3 states, respectively.

In order to vote during Region business, most chapters allotted each campus one vote. Region 1 allots each chapter 2 votes, one for the delegate and one for the alternate delegate. Region 5 allots votes based on each campus' enrollment such that one vote is given for every 100 students enrolled. Enrollment above 50 gains a vote (150 students = 2 votes). Region 7 allocates votes to states based on their representation at each Regional Meeting such that 1 vote is given for every three chapters that send a delegate to the Regional Meeting.

iii. Parliamentary Procedure

Table 4 outlines the body of parliamentary procedure utilized during business meetings for each region. Most regions adhere to the Standard Code of Parliamentary Procedure, which is the code followed by the AMA-MSS Assembly per MSS IOP IV.D.6.a. Region 2 utilizes the Sturgis Standard Code of Parliamentary Procedure and Regions 5 and 6 employ Davis' Rules of Order.

iv. Resolution Authorship

Table 5a outlines the systems each region utilizes to coordinate resolution writing. Table 5b outlines the bylaws that determine eligibility for region authorships. Most regions elect an Advocacy or Legislative Chair who oversees resolution writing and facilitates collaboration between regional chapters. In addition, Regions 2 and 5 create a resolution committee that oversees the resolution writing process. Region 6 has a legislative committee but the bylaws do not explicitly discuss its role in resolution management. Region 2's Resolution Committee decides whether a resolution will gain regional authorship. In contrast, Regions 1, 3, 4, and 7 vote mostly via online platforms to determine if a resolution can be authored on behalf of a region. Regions 1, 3 and 6 use a majority vote to determine region authorship eligibility. Regions 4, 5 and 7 have predetermined quorums required for regional authorship.

CONCLUSION

In conclusion, there are significant differences in the aforementioned categories of quorum, elections, parliamentary procedure, and policy authorship. These differences should be reviewed by region leadership. A primary aim of this report was to assess if regions included required bylaw elements as outlined in AMA-MSS GC Report D, A-15, "Evaluation of AMA-MSS Region Bylaws." The results of our analysis suggest that some Regions are still missing the minimum outlined bylaw requirements. COLRP highly recommends these Regions update their bylaws to ensure they have included all the minimum required elements. Additionally, this report reveals that the protocol by which authors gain region authorship and sponsorship of resolutions submitted to the MSS Assembly varies by region. Overall, this COLRP is hopeful that this comparative analysis will allow Regions to learn about other Region bylaws and understand the different approaches they employ to operate effectively.

RECOMMENDATIONS

In alignment with MSS policy 665.012MSS, your COLRP recommends the following:

1. That our MSS Speaker and Vice Speaker monitor all MSS Regions to ensure compliance with the minimum requirements in GC Report D, A-15; and
2. That our MSS COLRP reevaluate the accordancy of each Region's bylaws with the categories in Tables 1 – 5b and release its findings in an informational report to the Assembly at A-19; and
3. The remainder of this report be filed.

ACKNOWLEDGMENTS

This report was assembled by the 2016-17 AMA-MSS Committee on Long-Range Planning (Joseph Alecusan, J. Steven Ekman, Lauren Engel, Usman Hasnie, Spenser Hayward, Jonathan Hunt, Smriti Rajita Kumar, Nazish Malik, Kieran McAvoy, Anthony Naquin, Gabriel Pham, Matthew Rasmussen, Divyansh Sharma, Yuxing Xia, Vidhushei Yogeswaran)

Table 1: Inclusion of Minimum Bylaw Elements, Pursuant to GC Rep D A-15, By Region

	Clause stating a purpose of the Medical Student Region is to elect Regional Delegates to the HOD	Responsibilities of the Region Chair	Requirements of the Region Delegate Elections	Description of Regional Governing Council	How to Determine Regional Delegation Chair	Responsibilities of Regional Delegate Chair
Region 1	Present	Present	Present	Present	Present	Present
Region 2	Present	Present	Present	Absent	Present	Present
Region 3	Present	Present	Present	Present	Absent	Absent
Region 4	Absent	Present	Present	Absent	Absent	Absent
Region 5	Present	Present	Present	Present	Present	Present
Region 6	Absent	Present	Present	Present	Absent	Absent
Region 7	Absent	Present	Present	Present	Present	Absent

Table 2: Requirements for Quorum by Region

Region 1	One-third of all active chapters within Region 1 shall constitute a quorum
Region 2	A quorum shall constitute at least fifty (50) percent of all sections within Region 2 provided that at least four (4) states are represented.
Region 3	One third of all chapters in the region with at least three states represented
Region 4	One third of all chapters in the region with at least three states represented
Region 5	A quorum shall constitute at least fifty (50) percent of all sections provided that at least four 3 states are represented.
Region 6	One-third of all chapters within Region VI shall constitute a quorum provided that at least 3 states are represented.
Region 7	One-third of Region VII active chapters, provided that at least 3 (of the 7) states are represented

Table 3: Voting Allocation by Region

Region 1	Each Campus gets 2 votes
Region 2	Each Campus gets 1 vote
Region 3	Each Campus gets 1 vote
Region 4	Each Campus gets 1 vote
Region 5	Each Campus 1 vote for every 100 students enrolled. Above 50 gains a vote. (i.e. 150 students = 2 votes)
Region 6	Each Campus gets 1 vote
Region 7	Proportional allocation of votes to the states based on their representation at each Regional Meeting (1 vote for every three chapters that send a delegate to the Regional Meeting)

Table 4: Parliamentary Procedures by Region

Region 1	Standard Code of Parliamentary Procedure
Region 2	Sturgis Standard Code of Parliamentary Procedure
Region 3	Standard Code of Parliamentary Procedure
Region 4	Standard Code of Parliamentary Procedure
Region 5	Davis' Rules of Order
Region 6	Davis' Rules of Order
Region 7	Standard Code of Parliamentary Procedure

Table 5a. Policy Coordination Initiatives by Region

Region 1	Policy and Advocacy Chair to facilitate region resolution authorship
Region 2	Advocacy Chair + Resolution Committee that decides if they will support a resolution on behalf of the region
Region 3	Legislative Chair who facilitates communication about resolutions and collaborations between states and sections
Region 4	Resolution and Advocacy Chair
Region 5	Legislative Chair + Resolution Committee
Region 6	Legislation Committee - Not specified
Region 7	Advocacy Chair

Table 5b. Region Resolution Authorship Requirements by Region

Region 1	Majority Vote
Region 2	Resolution Committee
Region 3	Majority Vote
Region 4	A minimum of 10 chapters must vote, and the vote in favor must reach a majority.
Region 5	2/3 of the votes cast shall constitute a majority.
Region 6	Majority Vote
Region 7	60% majority of states is required with each state and minimum of 4 states voting

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report A
A-17

Subject: Biennial Review of Organizations Seated in the AMA-MSS Assembly
Presented by: Christopher Libby, Chair
Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

1
2 INTRODUCTION
3

4 The MSS Internal Operating Procedures (IOPs) and AMA Bylaws outline a mechanism for
5 establishing and maintaining National Medical Specialty Society (NMSS), Professional Interest
6 Medical Association (PIMA), and National Medical Student Organization (NMSO) representation
7 in the MSS Assembly. Among other requirements, organizations that have been granted voting
8 representation in the Assembly are required to undergo biennial review to ensure that they
9 remain eligible for representation in the MSS Assembly.

10
11 Accordingly, this report assesses whether NMSSs, PIMAs, and NMSOs currently represented in
12 the Assembly continue to meet the eligibility criteria and recommends continuation or not of
13 each organization's representation status.

14
15 BACKGROUND

16
17 A. *NMSS and PIMA Eligibility Criteria*
18

19 The student components of National Medical Specialty Societies (NMSSs) and Professional
20 Interest Medical Associations (PIMAs) are granted representation in the MSS Assembly
21 according to guidelines set forth in AMA Bylaw 7.3.3.3 and MSS IOP IX.C.2. The student
22 components of NMSSs and PIMAs that meet the following criteria may be considered for
23 representation in the MSS Assembly:

- 24
25 a. The parent organization must have voting representation in the AMA House of
26 Delegates.
27 b. The parent organization must allow for medical student membership.
28 c. The parent organization must have established a mechanism that allows for the regular
29 input of medical student views into the issues before the organization.
30

31 B. *New Representation*
32

33 New representation by a NMSS, PIMA, or NMSO is granted after an application submitted by
34 interested national medical specialty societies, federal services, and professional interest
35 medical associations to the MSS GC. The organization should submit the application form, and
36 any other documents demonstrating compliance with these criteria, to the MSS Governing
37 Council at least ninety days prior to the first Meeting at which they wish to seat an MSS

1 Delegate. Upon approval by the Governing Council, the organization will be granted a seat in
2 the MSS Assembly with voting privileges on all matters except elections. The newly seated
3 organization will be placed on probationary status for a period of two years, during which time
4 consistent attendance at the four national Assembly Meetings is expected. At the conclusion of
5 this probation period, the MSS Delegate selected by the organization will attain full voting
6 privileges, including elections, and will be eligible to run for office. The Governing Council will
7 notify the organization of its status at the end of the probation period. (MSS IOP X.C.2.c)

8 9 C. NMSO Eligibility Criteria

10 National Medical Student Organizations (NMSOs) are granted representation in the MSS
11 Assembly according to guidelines set forth in AMA Bylaw 7.3.3.4 and MSS IOP IX.C.3. NMSOs
12 that meet the following criteria may be considered for representation in the MSS Assembly:

- 14 a. The organization must be national in scope.
- 15 b. A majority of the voting members of the organization must be medical students enrolled
16 in educational programs as defined in AMA Bylaw 1.1.1.¹
- 17 c. Membership in the organization must be available to all medical students, without
18 discrimination.
- 19 d. The purpose and objectives of the organization must be consistent with the AMA's
20 purpose and objectives.²
- 21 e. The organization's code of medical ethics must be consistent with the AMA's Principles
22 of Ethics.³

23 24 25 DISCUSSION

26 27 A. Review of NMSS and PIMA Eligibility

28 There are currently 10 NMSSs and PIMAs represented in the MSS Assembly:

- 29 1. Aerospace Medical Association (AsMA)
- 30 2. American Academy of Family Physicians (AAFP)
- 31 3. American Academy of Pediatrics (AAP)
- 32 4. American Association of Physicians of Indian Origin (AAPI)
- 33 5. American College of Emergency Physicians (ACEP)
- 34 6. American College of Medical Quality (ACMQ)
- 35 7. American College of Physicians (ACP)
- 36 8. American Society of Addiction Medicine (ASAM)
- 37 9. American Society of Anesthesiologists (ASA)
- 38 10. American Society of Military Surgeons of the US (AMSUS)

39
40
41
42 Our review found that each of these organizations is in compliance with the established
43 eligibility criteria as required by biennial review. However, as part of the review, the American

¹ AMA Bylaw 1.1.1: "Medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the American Osteopathic Association leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical."

² The stated mission of the AMA is "To promote the art and science of medicine and the betterment of public health." (See <https://www.ama-assn.org/about/our-vision>).

³ The AMA Principles of Medical Ethics may be found at <https://www.ama-assn.org/delivering-care/ama-code-medical-ethics>.

1 Society of Addiction Medicine indicated that it no longer wished to remain eligible for
2 representation in the MSS Assembly at this time.; hence, it will not be discussed below.
3

4 A brief discussion of each organization follows:
5

6 1. Aerospace Medical Association (AsMA)

- 7 a. Aerospace Medical Association has voting representation in the House of
8 Delegates.
- 9 b. The AsMA Association allows for medical student membership.
- 10 c. The Aerospace Medicine Student and Resident Organization (AMSRO) has a
11 voting representative on the Aerospace Medical Association Council (Board of
12 Directors). All members of the Aerospace Medical Association, including Student
13 and Resident members can offer resolutions and nominations, etc.

14
15 2. American Academy of Family Physicians (AAFP)

- 16 a. AAFP has voting representation in the AMA House of Delegates.
- 17 b. The AAFP allows for medical student membership.
- 18 c. The AAFP Board of Directors includes a student member as do its Commissions.
19 In addition, the AAFP convenes a national meeting of students and residents
20 each summer. Resolutions considered at that meeting can be referred to the
21 Board of Directors and AAFP Congress of Delegates for consideration.
22

23 3. American Academy of Pediatrics (AAP)

- 24 a. AAP has voting representation in the House of Delegates
- 25 b. The AAP allows for medical student membership.
- 26 c. The AAP has a medical student section with its own subcommittees for
27 leadership opportunities. AAP has medical student liaisons to each of the
28 subcommittees.
29

30 4. American Association of Physicians of Indian Origin (AAPI)

- 31 a. AAPI has voting representation in the AMA House of Delegates.
- 32 b. The AAPI allows for medical student membership.
- 33 c. One medical student sits on the Executive Council of the parent organization.
34 One medical student sits on the Board of Trustees of the parent organization.
35 Two governing board meetings annually for the parent organizations to which
36 students can submit resolutions.
37

38 5. American College of Emergency Physicians (ACEP)

- 39 a. ACEP has voting representation in the AMA House of Delegates
- 40 b. The ACEP allows for medical student membership.
- 41 c. Medical students serve on the Section Council on Emergency Medicine. They
42 are members of the Emergency Medicine Residents' Association (EMRA) which
43 has a liaison to the ACEP Board of Directors and representation on the ACEP
44 Council. EMRA also has a Medical Student Council that provides student
45 viewpoints on issues critical to medical students and graduate medical education
46 concerns. Medical students also serve on various ACEP committees.
47

48 6. American College of Medical Quality (ACMQ)

- 49 a. ACMQ has voting representation in the AMA House of Delegates
- 50 b. The ACMQ allows for medical student membership.

- 1 c. A medical student currently sits on the board of directors. Additionally, ACMQ's
2 student/resident/fellows section represents medical student issues to the board
3 and membership.
4

5 7. American College of Physicians (ACP)

- 6 a. ACP has voting representation in the AMA House of Delegates
7 b. The ACP allows for medical student membership.
8 c. The ACP has a Council of Student Members. The Chair serves on the College's
9 Board of Regents, the Vice Chair, on the Board of Governors. The Council can
10 submit resolutions to either the Board of Regents or Board of Governors.
11

12 8. American Society of Anesthesiologists (ASA)

- 13 a. ASA has voting representation in the AMA House of Delegates.
14 b. The ASA allows for medical student membership.
15 c. The ASA Medical Student Component Society has a governing council and all
16 ASA medical student members are members of this component society. The
17 Medical Student Component is represented in the ASA House of Delegates. The
18 Medical Student Governing Council meets with the Committee on Residents &
19 Medical Students regularly. MS Governing Council recommendations are made
20 through the CORMS and directly to the ASA Board of Directors.
21

22 9. American Society of Military Surgeons of the US (AMSUS)

- 23 a. AMSUS has voting representation in the AMA House of Delegates
24 b. AMSUS allows for medical student membership. The first year is federally
25 funded, and then \$50 per year through to residency completion.
26 c. Students have their own SIG (special interest group) that is managed and run by
27 USUHS medical students. Their elected leader meets at least annual with the
28 AMSUS Executive Director to review their goals, needs, and express their point
29 of view. Student members are invited to volunteer at the annual meeting, giving
30 them the opportunity to network with top military leadership from DoD, VA, DHA
31 etc. as well as fellow students from different health related professions, schools,
32 and military branches.
33

34 *B. New Representation*

35
36 One PIMA organization has sought representation in the MSS Assembly since the release of
37 GC Report B, A-15:
38

39 1. American Medical Women's Association (AMWA)

40
41 A brief discussion of this organization follows:
42

43 1. American Medical Women's Association (AMWA)

- 44 a. AMWA has voting representation in the House of Delegates
45 b. AMWA allows for medical student membership.
46 c. The Medical Student Division is structured by the local, regional, and national
47 levels. We have active members active at every level. Our Student Executive
48 Committee is composed of President, President-Elect, Secretary, and Treasurer.
49 Our President-Elect serves as the President the following year, and Immediate
50 Past President after that, to provide continuity on the leadership board. In

1 addition, many of our regional leaders transition to national chair positions, which
2 also provide added consistency throughout AMWA. The tenure is yearly for most
3 positions, while some are two-year positions (ie. Treasurer, Conference Chairs).
4

5 Our review found that this organization is in compliance with the established eligibility criteria for
6 probationary representation in the AMA-MSS Assembly starting at A-17.
7

8 *C. Review of NMSO Eligibility*

9

10 There are currently four NMSOs represented in the MSS Assembly:
11

- 12 1. American Physician Scientists Association (APSA)
 - 13 2. Asian Pacific American Medical Student Association (APAMSA)
 - 14 3. Latino Medical Student Association (LMSA)
 - 15 4. Student National Medical Association (SNMA)
- 16

17 Our review found that each of these organizations is in compliance with the established criteria
18 for eligibility. We note that SNMA is a NMSO, not NMSS or PIMA as was incorrectly indicated in
19 GC Report B, A-15. SNMA has confirmed it has had in place the requisite elements for NMSO
20 representation since 2015. The categorization of SNMA as an NMSO is not a grant of new
21 representation; it only corrects an error made in the A-15 report. Moreover, SNMA was properly
22 categorized as an SNMA in COLRP Report B, A-13 Biennial Review of Organizations Seated in
23 the AMA-MSS Assembly. A brief discussion of these organizations follows:
24

25 1. American Physician Scientists Association (APSA)

- 26 a. The APSA is national in scope.
 - 27 b. A majority of the voting members of the organization are medical students currently
28 enrolled in U.S. medical schools as defined by AMA Bylaw 1.1.1.
 - 29 c. Membership to the organization is available to all medical students.
 - 30 d. The purpose and objectives of the organization are consistent with the AMA's
31 purpose and objectives.
 - 32 e. The APSA does not have a specific code of ethics, but its objectives are in line with
33 the AMA Principles of Ethics.
- 34

35 2. Asian Pacific American Medical Student Association (APAMSA)

- 36 a. The APAMSA is national in scope.
 - 37 b. A majority of the voting members of the organization are medical students enrolled in
38 U.S. medical schools as defined by AMA Bylaw 1.1.1.
 - 39 c. Membership in the organization is available to all medical students.
 - 40 d. The purpose and objectives of the organization are consistent with the AMA's
41 purpose and objectives.
 - 42 e. The APAMSA does not currently have a code of ethics, but its stated mission and
43 objectives are in line with the AMA principles of medical ethics.
- 44

45 3. Latino Medical Student Association (LMSA)

- 46 a. The LMSA is national in scope.
- 47 b. A majority of the voting members of the organization are medical students enrolled in
48 U.S. medical schools as defined by AMA Bylaw 1.1.1.
- 49 c. Membership in the organization is available to all medical students.

- 1 d. The purposes and objectives of the association are consistent with the AMA's
2 purpose and objectives.
3 e. The LMSA does not currently have a code of ethics, but its stated mission and
4 objectives are in line with the AMA principles of medical ethics.
5
6 4. Student National Medical Association (SNMA)
7 a. The SNMA is national in scope.
8 b. A majority of the voting members of the organization are medical students enrolled in
9 U.S. medical schools as defined by AMA Bylaw 1.1.1.
10 c. Membership in the organization is available to all medical students.
11 d. The purposes and objectives of the association are consistent with the AMA's
12 purpose and objectives.
13 e. The SNMA does not currently have a code of ethics, but its stated mission and
14 objectives are in line with the AMA principles of medical ethics.
15

16 **CONCLUSIONS**

17
18 Your GC's review of the continuing representation eligibility of NMSSs, PIMAs, and NMSOs
19 currently represented in the MSS Assembly is summarized in Tables 1 and 2. Table 3 indicates
20 the representation components of newly-seated NMSSs and PIMAs. Table 4 indicates the
21 representation components of newly-seated NMSOs.

Table 1: Review of NMSS and PIMA Eligibility

Organization	Parent Seated in HOD?	Student Membership?	Student Input?
AsMA	Yes	Yes	Yes
AAFP	Yes	Yes	Yes
AAP	Yes	Yes	Yes
AAPI	Yes	Yes	Yes
ACEP	Yes	Yes	Yes
ACMQ	Yes	Yes	Yes
ACP	Yes	Yes	Yes
ASA	Yes	Yes	Yes
AMSUS	Yes	Yes	Yes

Table 2: Review of NMSO Eligibility

Organization	National?	Majority med students?	Open to all med students?	Consistent with AMA purposes and objectives?	Code of medical ethics consistent with AMA?
APSA	Yes	Yes	Yes	Yes	Yes
APAMSA	Yes	Yes	Yes	Yes	Yes
LMSA	Yes	Yes	Yes	Yes	Yes
SNMA	Yes	Yes	Yes	Yes	Yes

Table 3: Newly-Seated Organizations (NMSS and PIMA)

Organization	Parent Seated in HOD?	Student Membership?	Student Input?	Organization type
AMWA	Yes	Yes	Yes	PIMA

1 Additionally, your GC notes that the presence and active involvement of NMSO/NMSS/PIMAs in
2 the MSS Assembly provides a valuable opportunity for more medical student views to be
3 represented in the AMA-MSS, as well as an opportunity for the AMA-MSS to hear
4 underrepresented opinions, foster contacts and build partnerships with similar organizations,
5 and improve the diversity of our membership.

6
7 Thus, your MSS Governing Council recommends that the findings of this report be filed:

- 8
9 1. The AMA-MSS retains the following NMSSs and PIMAs as eligible for AMA-MSS
10 Assembly representation: American Academy of Family Physicians (AAFP), American
11 Academy of Pediatrics (AAP), American Association of Physicians of Indian Origin
12 (AAPI), American College of Emergency Physicians (ACEP), American College of
13 Medical Quality (ACMQ), American College of Physicians (ACP), American Society of
14 Anesthesiologists (ASA), American Society of Military Surgeons of the US (AMSUS)
15
- 16 2. The AMA-MSS terminates the following organization’s representation status in the MSS
17 Assembly until such time that the organization wishes to reapply for representation:
18 American Society of Addiction Medicine (ASAM)
19
- 20 3. The AMA-MSS grants a seat in the MSS Assembly with voting privileges on all matters
21 except elections to the following newly-seated PIMA: American Medical Women’s
22 Association (AMWA).
23
- 24 4. The AMA-MSS retains the following NMSOs as eligible for AMA-MSS Assembly
25 representation: American Physician Scientists Association (APSA), Asian Pacific
26 American Medical Student Association (APAMSA), Latino Medical Student Association
27 (LMSA), and Student National Medical Association (SNMA).

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report B
A-17

Subject: Review of AMA-MSS Statements of Support for HOD Policies

Presented by: Christopher Libby, Chair

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

INTRODUCTION

Since 1993, the MSS has employed a reaffirmation calendar as a means for generating policy. This mechanism is codified in MSS policy 630.037 Reaffirmation Calendar:

AMA-MSS will implement and use a reaffirmation consent calendar akin to that used by the AMA-HOD and set forth in AMA Policy 545.979 and 545.974, to expedite the business of the Assembly on resolutions seeking reaffirmation of existing AMA-MSS policy. The Reaffirmation Calendar will provide “statements of support” for existing AMA policy for those resolutions deemed identical or nearly identical to existing AMA policy.

The “statements of support” for existing AMA policy resulting from this process have been catalogued and compiled at the end of the MSS Digest of Policy Actions (<https://www.ama-assn.org/sites/default/files/media-browser/a16-mss-digest-policy-actions-v2.pdf>). These statements have not been reviewed since their inclusion in the Digest; in the intervening time, some of the formally-supported policies have been rescinded by the AMA or consolidated into other AMA policies, leaving the statements of support without meaning. Other policies have been reaffirmed by the MSS multiple times, leading to the inclusion of redundant statements of support.

MSS POLICY REVIEW

The MSS GC conducted a review of every AMA policy formally supported by the MSS. Appendix 1 of this report contains a listing of the 28 policies that are no longer extant AMA policies and ten extant AMA policies which have been reaffirmed more than once. Many of the 28 outdated policies called for a specific finite action, such as preparing a letter, amending a policy, creating a product, or conducting a study; the statements of support associated with these policies have been recommended for rescission. There are six policies that have been consolidated into other policies or updated with the adoption of the new *AMA Code of Medical Ethics* since their reaffirmations. In these cases, reaffirmation of the updated or consolidated policy has been recommended in lieu of the statement of support for the since-rescinded AMA policy, as the directives or stances contained therein continue to be relevant. In the case of the ten policies that have been reaffirmed multiple times, rescission of the older reaffirmations is recommended, leaving a single statement of support for each such policy.

RECOMMENDATIONS

Your AMA-MSS Governing Council recommends that the following be adopted and the remainder of the report be filed:

1. That the formally-supported policies specified for action in Appendix 1 of this report be acted upon as recommended.
2. That the AMA-MSS Governing Council review the “AMA-MSS Statements of Support for HOD Policies” section of the AMA-MSS Digest of Policy Actions every five years for redundant and outdated statements of support.

Appendix 1 – Policy Sunset Report Recommendations for 2011 AMA-MSS Policies

Policy Number, Title, Policy	GC Recommendation
<p><u>D-60.978 Resources to Combat Teen and Young Adult Suicide in the United States</u> Our AMA will convene a time-limited work group to meet through conference call to identify and evaluate appropriate resources for physicians intended to prevent and reduce teen and young adult suicide, and that such resources be maintained on a publicly accessible Web page hosted by our AMA. (Reaffirmed A-11; D-60.978 no longer in AMA policy)</p>	<p>Rescind- Discrete action, language no longer in AMA policy</p>
<p><u>D-60.979 Childhood Anaphylactic Reactions</u> Our AMA will: (1) summarize the most recent scientific literature pertaining to the increased incidence of anaphylactic reactions in children; (2) develop specific strategies aimed at reducing the incidence of anaphylactic reactions among children; and (3) support legislative efforts to ensure that children have appropriate access to necessary medical interventions for the treatment of asthma and acute anaphylactic reactions in school settings. (Reaffirmed A-14; D-60.979 no longer in AMA policy)</p>	<p>Rescind- Discrete action (partially), language no longer in AMA policy</p>
<p><u>D-60.983 Teen and Young Adult Suicide in the United States</u> Our AMA will work with appropriate federal agencies, national organizations, and medical specialty societies to compile resources to reduce teen and young-adult suicide, including but not limited to continuing medical education classes, patient education programs, and other appropriate educational and interventional programs for health care providers, and report back at the 2006 Interim Meeting. (Reaffirmed A-11; D-60.983 no longer in AMA policy)</p>	<p>Rescind- Discrete action, language no longer in AMA policy</p>
<p><u>D-60.988 Early Childhood and Family Education as a Mechanism to Advance Family Health</u> Our AMA will advocate for the continuation and expansion of early childhood family education programs nationwide. (Reaffirmed A-13; D-60.988 no longer in AMA policy)</p>	<p>Rescind- No similar language in extant AMA policy</p>
<p><u>D-60.990 Exercise and Healthy Eating for Children</u> Our AMA shall: (1) seek legislation that would require the development and implementation of evidence-based nutrition standards for all food served in K-12 schools irrespective of food vendor or provider; and (2) work with the US Public Health Service and other federal agencies, the Federation, and others in a coordinated campaign to educate the public on the epidemic of childhood obesity and enhance the K-12 curriculum by addressing the benefits of exercise, physical fitness, and healthful diets for children. (Reaffirmed I-07 and I-10; D-60.990 no longer in AMA policy)</p>	<p>Rescind I-07 and I-10 reaffirmations- No similar language in extant AMA policy</p>
<p><u>D-60.992 Bullying Behaviors Among Children and Adolescents</u> Our AMA shall work with appropriate federal agencies, medical societies, the Alliance, mental health organizations, education</p>	<p>Rescind- Discrete action, language no longer in AMA policy</p>

<p>organizations, schools, youth organizations, and others in a national campaign to change societal attitudes toward and tolerance of bullying, and advocate for multifaceted age and developmentally appropriate interventions to address bullying in all its forms. (Reaffirmed A-11; D-60.992 no longer in AMA policy)</p>	
<p><u>D-140.976 Advance Health Care Directive</u> Our AMA will: (1) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD) as soon as reasonably possible; (2) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (3) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (4) create other strategies to help physicians encourage all their patients to complete their DPAHC/AD; (5) work with Congress and the Department of Health and Human Services to make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD as soon as reasonably possible; and (6) advocate for the implementation of secure electronic advance health care directives. (Reaffirmed A-14; D-140.976 no longer in AMA policy)</p>	<p>Consolidated into H-140.845 Encouraging the Use of Advance Directives and Health Care Powers of Attorney- Reaffirm H-140.845 instead</p>
<p><u>D-165.952 National Health Care Policy Agenda</u> 1. Our AMA will synthesize current AMA policy for the specific purpose of advocating a comprehensive, patient-centered National Health Care Policy Agenda. 2. This Agenda will strongly address the most important issues affecting physicians and patients in the United States, such as public- and private-sector financing and delivery, care for the uninsured, wellness and personal responsibility, liability, patient safety, and health information technology, and recommend comprehensive and workable solutions. 3. Our AMA will develop an appropriate mechanism to present a draft of the National Health Care Policy Agenda to members of the House of Delegates at the earliest opportunity prior to the 2007 Annual Meeting to allow delegates an appropriate period of time to review and offer feedback prior to the 2007 Annual Meeting. 4. A forum on the National Health Care Policy Agenda will be held at the 2007 Annual Meeting to debate and offer feedback to the Board of Trustees. 5. Once finalized, our AMA will use the National Health Care Policy Agenda as a framework for discussion with leaders of United States medicine, business, health care, employers, and government. 6. Our AMA will present the National Health Care Policy Agenda to the President of the United States, the Congress, the American people, and the major political parties by August 31, 2007, so that it can appropriately frame and drive the health care policy debate in the 2008 presidential election.</p>	<p>Rescind I-07 and I-08 reaffirmations- Discrete action, language no longer in AMA policy</p>

<p>(Reaffirmed I-07 and I-08; D-165.952 no longer in AMA policy)</p>	
<p><u>D-170.997 Sun Protection Programs in Elementary Schools</u> Our AMA will work with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage elementary schools to develop sun protection policies. (Reaffirmed I-05; D-170.997 no longer in AMA policy)</p>	<p>Rescind- No similar language in extant AMA policy</p>
<p><u>D-200.984 Incentive Programs to Improve Access to Care in Underserved Areas</u> 1. Our American Medical Association, in collaboration with state and medical specialty societies, will continue to collect and disseminate information on the efficacy of various types of incentive and other programs designed to promote recruitment and retention of physicians in underserved areas. 2. Based on the analysis of the efficacy of the various types of incentive programs, our AMA will advocate to the federal government, the states, and the private sector for enhanced support for successful models. (Reaffirmed I-08; D-200.984 no longer in AMA policy)</p>	<p>Rescind- No similar language in extant AMA policy</p>
<p><u>D-200.989 Incentive Programs to Improve Access to Health Care Services in Underserved Areas</u> Our AMA will (1) conduct an analysis of the creative use of tax credits, student loan deferment and loan forgiveness programs, J-1 visa waivers, and practice subsidies as financial incentives to physicians for providing care in identified underserved areas; and (2) work with state medical societies and other appropriate entities to identify, catalogue, and evaluate the effectiveness of incentive programs, including the J-1 visa waiver program, designed to promote the location and retention of physicians in rural and urban underserved areas and, consequently, improve patient access to health care in these areas. (Reaffirmed I-08; D-200.989 no longer in AMA policy)</p>	<p>Rescind- No similar language in extant AMA policy</p>
<p><u>D-265.989 Medical-Legal Partnerships to Improve Health and Well Being</u> Our AMA: (1) encourages physicians to develop medical-legal partnerships (MLPs) to help identify and resolve diverse legal issues that affect patients' health and well-being; (2) will work with physician groups and other key stakeholder organizations such as the American Bar Association and the Legal Services Corporation to: (a) educate physicians on the impact of unmet legal needs on the health of patients; (b) will provide physicians with information on screening for such unmet legal needs in their patients; and (c) provide physicians, hospitals and health-centers with information on establishing a Medical-Legal Partnership; and (3) will create a model medical-legal partnership agreement for physicians to utilize</p>	<p>Rescind- No similar language in extant AMA policy</p>

<p>as guidance when entering into such an agreement. (Reaffirmed A-12; D-265.989 no longer in AMA policy)</p>	
<p><u>D-295.958 Support of Business of Medicine Education for Medical Students</u> Our AMA will encourage all US medical schools to provide students with a basic foundation in medical business, drawing upon curricular domains referenced in Undergraduate Medical Education for the 21st Century (UME-21), in order to assist students in fulfilling their professional obligation to patients and society in an efficient, ethical, and cost-effective manner. (Reaffirmed A-15; D-295.958 no longer in AMA policy)</p>	<p>Rescind- No similar language in extant AMA policy</p>
<p><u>D-305.975 Long-Term Solutions to Medical Student Debt</u> Our AMA will: (1) through its Council on Medical Education, continue a comprehensive study of medical education financing, with a report back to the House of Delegates at the 2005 Annual Meeting; (2) encourage medical schools and state medical societies to consider the creation of self-managed, low-interest loan programs for medical students, and collect and disseminate information on such programs; (3) advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas; (4) work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment; and (5) collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided. (Reaffirmed twice at I-08)</p>	<p>Rescind one copy of I-08 reaffirmation- redundant</p>
<p><u>D-305.993 Medical School Financing, Tuition, and Student Debt</u> (1) The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of developing a web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection and loan repayment programs, and a rotating loan program; and creating an AMA scholarship program funded through philanthropy. The AMA also should collect and disseminate information on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other purposes. (2) Our AMA will vigorously advocate for ongoing, adequate funding for federal and state programs that provide scholarship or loan repayment funds in return for service, including funding in return for practice in underserved areas, participation in the military, and participation in academic medicine or clinical research. Obtaining</p>	<p>Rescind both I-08 reaffirmations- redundant</p>

<p>adequate support for the National Health Service Corps and similar programs, tied to the demand for participation in the programs, should be a focus for AMA advocacy efforts. (3) Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition. (4) Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students. (5) Our AMA will urge the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements to include a requirement that financial planning/debt management counseling be provided for resident physicians. (6) Our AMA will work with other organizations, including the Association of American Medical Colleges, residency program directors groups, and members of the Federation, to develop and disseminate standardized information, for example, computer-based modules, on financial planning/debt management for use by medical students, resident physicians, and young physicians. (7) Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of increasing loan deferment through the period of residency, promoting the expansion of subsidized loan programs, eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans. (Reaffirmed twice at I-08 and I-11)</p>	
<p><u>D-310.968 Physician and Medical Student Burnout</u> 1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students. 2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets. 3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students. 4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community. 5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements. 6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout. (Reaffirmed I-14 and I-16)</p>	<p>Rescind I-14 reaffirmation- redundant</p>
<p><u>D-370.990 Umbilical Cord Blood Transplantation: The Current Scientific Understanding</u> Our AMA will: (1) encourage continued research into the scientific</p>	<p>Very similar language in H- 370.961 Umbilical Cord Blood Transplantation: The Current</p>

<p>issues surrounding the use of umbilical cord blood-derived hematopoietic stem cells for transplantation, including the ex vivo expansion of umbilical cord blood-derived hematopoietic stem cells; the combination of multiple units of closely matched, unrelated umbilical cord blood cells for transplantation; and the improvement of umbilical cord blood cells collection techniques; and (2) work with appropriate organizations to educate physicians and the public about the potential benefits of, and limitations to, umbilical cord blood transplantation as an alternative to bone marrow transplantation. (Reaffirmed I-10; D-370.990 no longer in AMA policy)</p>	<p>Scientific Understanding- Reaffirm H-370.961 instead</p>
<p><u>D-435.984 Tort Reform</u> Our AMA will: (1) continue to pursue MICRA-based reform as the top priority; (2) continue to pursue liability reform efforts by any and all legislative options that would fundamentally change our medical liability system to create fair and equitable remuneration for injured patients and to promote patients' access to health care; and (3) report on its coalition building activities on efforts to reform our civil justice system and make this report available to the general membership by the 2005 Annual Meeting. (Reaffirmed A-10; D-435.984 no longer in AMA policy)</p>	<p>Rescind- Discrete action (partially), covered under other reaffirmed policy</p>
<p><u>D-440.971 Recommendations for Physician and Community Collaboration on the Management of Obesity</u> Our AMA will: (1) work with the Centers for Disease Control and Prevention to convene relevant stakeholders to evaluate the issue of obesity as a disease, using a systematic, evidence-based approach; (2) continue to actively pursue measures to treat obesity as an urgent chronic condition, raise the public's awareness of the significance of obesity and its related disorders, and encourage health industries to make appropriate care available for the prevention and treatment of obese patients, as well as those who have co-morbid disorders; (3) encourage physicians to incorporate body mass index (BMI) and waist circumference as a component measurement in the routine adult physical examination, and BMI percentiles in children recognizing ethnic sensitivities and its relationship to stature, and the need to implement appropriate treatment or preventive measures; (4) promote use of our Roadmaps for Clinical Practice: Assessment and Management of Adult Obesity primer in physician education and the clinical management of adult obesity; (5) develop a school health advocacy agenda that includes funding for school health programs, physical education and physical activity with limits on declining participation, alternative policies for vending machines that promote healthier diets, and standards for healthy a la carte meal offerings. Our AMA will work with a broad partnership to implement this agenda; and (6) collaborate with the CDC, the Department of Education, and other appropriate agencies and organizations to consider the feasibility of convening school health education, nutrition, and exercise representatives, parents, teachers and education organizations, as</p>	<p>Rescind- No similar language in extant AMA policy</p>

<p>well as other national experts to review existing frameworks for school health, identify basic tenets for promoting school nutrition and physical activity (using a coordinated school health model), and create recommendations for a certificate program to recognize schools that meet a minimum of the tenants. (Reaffirmed I-10; D-440.971 no longer in AMA policy)</p>	
<p><u>D-478.994 Health Information Technology</u> Our AMA will: (1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT); (2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT; and (3) support initiatives to ensure interoperability among all HIT systems. (Reaffirmed I-07, I-08, and I-10)</p>	<p>Rescind I-07 and I-08 reaffirmations- redundant</p>
<p><u>D-478.995 National Health Information Technology</u> 1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. 2. Our AMA: (A) advocates for standardization of key elements of EMR user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EMR user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care. (Reaffirmed I-07 and I-08)</p>	<p>Rescind I-07 reaffirmation- redundant</p>
<p><u>D-478.996 Information Technology Standards and Costs</u> Our AMA will: (1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems; (4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information</p>	<p>Rescind I-07 and I-08 reaffirmations- redundant</p>

<p>technology systems. (Reaffirmed I-07, I-08, and I-10)</p>	
<p><u>D-480.975 Guidelines for Mobile Medical Applications and Devices</u> Our AMA will prepare a report on the appropriate indications, guidelines and certification processes necessary to assure the efficacy and safety of mobile medical applications and devices developed for smartphones and other personal electronic devices that may be used by physicians, allied health professionals, caregivers and patients. (Reaffirmed I-14; D-480.975 no longer in AMA policy)</p>	<p>Rescind- Discrete action, language no longer in AMA policy</p>
<p><u>D-480.998 Minimal Standards for Medical Product Reuse</u> (1) Our AMA will encourage the development of a set of guidelines for processing medical supplies and instruments which may be reused. (2) These guidelines address the issues of product performance, safety and sterility. (3) These guidelines be distributed to the health care industry. (Reaffirmed I-14; D-480.998 no longer in AMA policy)</p>	<p>Rescind- No similar language in extant AMA policy</p>
<p><u>D-515.993 Support for Legislative Action and Improved Research on the Health Response to Violence and Abuse</u> Our AMA, in conjunction with other members of the Federation and the National Advisory Council on Violence and Abuse will: (1) identify and actively support state and federal legislative proposals designed to increase scientific knowledge, promote public and professional awareness, enhance recognition and ensure access to appropriate medical services for patients who have experienced violence and/or abuse; (2) actively support legislation and congressional authorizations designed to increase the nation's health care infrastructure addressing violence and abuse including proposals like the Health CARES (Child Abuse Research, Education and Services) Network; (3) actively support expanded funding for research on the primary prevention of violence and abuse, the cost of violence and abuse to the health care system, and the efficacy of interventions and methods utilized in the identification and treatment of victims of violence and abuse; (4) actively study the best practices in diagnosis and management of family violence (including an analysis of studies not reviewed in the recent US Preventive Services Task Force Recommendations on Screening for Family Violence) and present a report that identifies future research and practice recommendations; and (5) invite a Federation-wide task force to review and promote the best practices in the identification, management and prevention of family violence. (Reaffirmed I-13; D-515.993 no longer in AMA policy)</p>	<p>Rescind- No similar language in extant AMA policy</p>
<p><u>E-8.061 Gifts to Physicians from Industry</u> Many gifts given to physicians by companies in the pharmaceutical, device, and medical equipment industries serve an important and socially beneficial function. For example, companies have long provided funds for educational seminars and conferences. However, there has been growing concern about certain gifts from</p>	<p>Updated to 9.6.2 Gifts to Physicians from Industry with the adoption of the new AMA Code of Medical Ethics- Reaffirm 9.6.2 instead</p>

industry to physicians. Some gifts that reflect customary practices of industry may not be consistent with the Principles of Medical Ethics. To avoid the acceptance of inappropriate gifts, physicians should observe the following guidelines: (1) Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted. The use of drug samples for personal or family use is permissible as long as these practices do not interfere with patient access to drug samples. It would not be acceptable for non-retired physicians to request free pharmaceuticals for personal use or use by family members. (2) Individual gifts of minimal value are permissible as long as the gifts are related to the physician's work (eg, pens and notepads). (3) The Council on Ethical and Judicial Affairs defines a legitimate "conference" or "meeting" as any activity, held at an appropriate location, where (a) the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse (one or more educational presentation(s) should be the highlight of the gathering), and (b) the main incentive for bringing attendees together is to further their knowledge on the topic(s) being presented. An appropriate disclosure of financial support or conflict of interest should be made. (4) Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy directly to a physician by a company's representative may create a relationship that could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor who in turn can use the money to reduce the conference's registration fee. Payments to defray the costs of a conference should not be accepted directly from the company by the physicians attending the conference. (5) Subsidies from industry should not be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging, and meal expenses. Token consulting or advisory arrangements cannot be used to justify the compensation of physicians for their time or their travel, lodging, and other out-of-pocket expenses. (6) Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected

<p>educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution. Carefully selected educational conferences are generally defined as the major educational, scientific or policy-making meetings of national, regional, or specialty medical associations. (7) No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should belong to the organizers of the conferences or lectures. (Reaffirmed A-12)</p>	
<p><u>H-55.980 Skin Cancer Self-Examination</u> The AMA (1) encourages all physicians to perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (2) encourages physicians to examine their patients' skins for the early detection of melanoma and non-melanoma skin cancer; (3) urges physicians to encourage their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; and (4) encourages physicians to educate their patients concerning the correct way to perform skin self-examination. (Reaffirmed A-99; H-55.980 no longer in AMA policy)</p>	<p>Consolidated into H-55.972 Early Detection and Prevention of Skin Cancer- Reaffirm H-55.972 instead</p>
<p><u>H-60.944 Use of Psychotropic Drugs in Children, Adolescents, and Young Adults</u> Our AMA: (1) endorses efforts to train additional qualified clinical investigators in pediatrics, child psychiatry, and therapeutics to carry out studies related to the effects of psychotropic drugs in children, adolescents, and young adults; and (2) promotes efforts to educate physicians about the appropriate use of psychotropic medications in the treatment of children, adolescents, and young adults. (Reaffirmed I-10; H-60.994 no longer in AMA policy)</p>	<p>Rescind- No similar language in extant AMA policy</p>
<p><u>H-95.999 Disposable Syringes</u> The AMA requests manufacturers of disposable hypodermic needles and syringes to adopt designs to prevent reuse, and to include in the packaging clear directions for their correct disposal. (Reaffirmed I-14; H-95.999 no longer in AMA policy)</p>	<p>Consolidated into H-95.942 Safe Disposal of Used Syringes, Needles and Other Sharps in the Community- Reaffirm H-95.942 instead</p>
<p><u>H-120.960 Protection for Physicians Who Prescribe Pain Medication</u> Our AMA supports the following: (1) the position that physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution. It is the policy of the AMA that state</p>	<p>Rescind I-11 reaffirmation- redundant</p>

<p>medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain before seeking the implementation of legislation to provide that protection; (2) education of medical students and physicians to recognize addictive disorders in patients, minimize diversion of opioid preparations, and appropriately treat or refer patients with such disorders; and (3) the prevention and treatment of pain disorders through aggressive and appropriate means, including the continued education of doctors in the use of opioid preparations.</p> <p>Our AMA opposes harassment of physicians by agents of the Drug Enforcement Administration in response to the appropriate prescribing of controlled substances for pain management. (Reaffirmed I-11 and I-16)</p>	
<p><u>H-150.962 Quality of School Lunch Program</u> The AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines. (Reaffirmed I-05 and I-13)</p>	<p>Rescind I-05 reaffirmation- redundant</p>
<p><u>H-185.975 Requiring Third Party Reimbursement Methodology be Published for Physicians</u> Our AMA: (1) urges all third party payers and self-insured plans to publish their payment policies, rules, and fee schedules; (2) pursues all appropriate means to make publication of payment policies and fee schedules a requirement for third party payers and self-insured plans; (3) will develop model state and federal legislation that would require that all third party payers and self-insured plans publish all payment schedule updates, and changes at least 60 days before such changes in payment schedules are enacted, and that all participating physicians be notified of such changes at least 60 days before changes in payment schedules are enacted. (4) seeks legislation that would mandate that insurers make available their complete payment schedules, coding policies and utilization review protocols to physicians prior to signing a contract and at least 60 days prior to any changes being made in these policies; (5) works with the National Association of Insurance Commissioners, develop model state legislation, as well developing national legislation affecting those entities that are subject to ERISA rules; and explore the possibility of adding payer publication of payment policies and fee schedules to the Patient Protection Act; and (6) supports the following requirements: (a) that all payers make available a copy of the executed contract to physicians within three business days of the request; (b) that all health plan EOBs contain documentation regarding the precise contract used for determining the reimbursement rate; (c) that once a year, all contracts must be made available for physician review at no cost; (d) that no contract may be changed without the physician's prior written authorization; and (e) that when a contract is terminated</p>	<p>Rescind I-99 reaffirmation- redundant</p>

<p>pursuant to the terms of the contract, the contract may not be used by any other payer. (Reaffirmed I-99 and A-12)</p>	
<p><u>H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured</u> AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients; (2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible. (3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches; (4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs; (5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care; (6) urges states to administer their Medicaid and SCHIP programs through a single state agency; (7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs; (8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid</p>	<p style="text-align: center;">Rescind A-02 and I-05 reaffirmations- redundant</p>

funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children; (9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services; (10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals; (11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care; (12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income; (13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care; (14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs; (15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance; (16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living; (17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments; (18) urges CMS to require states to use its simplified four-page combination Medicaid /Children's Health Insurance Program (CHIP) application form for enrollment in these programs,

<p>unless states can indicate they have a comparable or simpler form; and (19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations. (Reaffirmed A-02, I-05, and I-12)</p>	
<p><u>H-295.906 Cardiopulmonary Resuscitation and Basic Life Support Training for First-Year Medical Students</u> Our AMA encourages training of cardiopulmonary resuscitation and basic life support to first-year medical students, preferably during the first term. (Reaffirmed I-05; H-295.906 no longer AMA policy)</p>	<p>Consolidated into H-300.945 Proficiency of Physicians in Basic and Advanced Cardiac Life Support- Reaffirm H-300.945 instead</p>
<p><u>H-345.992 Health Insurance Coverage of Psychiatric Illness</u> Our AMA: (1) reaffirms its support for the provision of benefits for emotional and mental illness under all governmental and private insurance programs which are equivalent in scope and duration to those benefits provided for other illnesses; (2) reaffirms its support for the continued expansion and improvement of peer review of the quality, necessity, and appropriateness of psychiatric services, and encourages all third party payers to work with and to utilize the resources of appropriate medical specialty groups in implementing such review; (3) supports development of model legislation for use by states to require all insurance companies that offer either group or individual coverage of hospital, medical, and surgical services to make available for purchase and affirmatively offer coverage of psychiatric services comparable with the coverage provided for other illnesses in their standard group and individual policies; and (4) supports legislation designed to expand psychiatric benefits provided under publicly financed programs of health care to a level comparable with those provided for other illnesses. (Reaffirmed I-98; H-345.992 no longer AMA policy)</p>	<p>Rescind- No similar language in extant AMA policy</p>
<p><u>H-440.895 Antimicrobial Use and Resistance</u> Our AMA is opposed to the use of antimicrobials at non-therapeutic levels in agriculture, or as pesticides or growth promoters, and urges that non-therapeutic use in animals of antimicrobials (that are also used in humans) should be terminated or phased out based on scientifically sound risk assessments. (Reaffirmed I-13; H-440.895 no longer AMA policy)</p>	<p>Rescind- No similar language in extant AMA policy</p>
<p><u>H-440.911 Medicine/Public Health Initiative</u> The AMA endorses the following recommendations of the Medicine/Public Health Initiative: Recommendation 1. Engage the community. Seek to change existing thinking within academic health centers, health-oriented community organizations, health care delivery systems and providers, and among health care purchasers to focus on improving the health of the community. Specific local implementation strategies might include: (a) Organizing health-oriented networks of community institutions to improve health of vulnerable populations and the community at large. (b) Stimulating the institutional and curriculum changes</p>	<p>Rescind- Medicine/Public Health Initiative no longer active, no similar language in extant AMA policy</p>

necessary for academic health centers to develop interdisciplinary teams to work with communities to improve their health. (c) Establishing community-based research programs that focus on locally relevant health problems and develop knowledge likely to benefit the community.

Recommendation 2. Change the education process. Enhance the practice of medicine and public health by expanding public health's understanding of medicine and medicine's understanding of public health. Specific strategies might include: Public health help for medicine through providing clinicians with better means to analyze procedures and resource use, and to think epidemiologically and statistically. Medicine's help for public health to understand the full meaning of the care of a patient, and also how to mobilize the practice community to better implement disease prevention and health promotion goals. A common core of knowledge taught to all students of public health and medicine. An organizational strategy to accomplish cross-over education, eg, jointly sponsored program tracks and department to department program affiliations between public health and medical schools, and program agreements for special instruction and training with health departments, health care delivery systems, and practitioners. Giving medical and public health students and medical residents the training and clinical opportunities to learn to function as a team to improve health and serve individuals in the context of their communities. Targeting younger audiences, including high school and college students, to encourage participation in and learning about the relation between medicine and public health.

Recommendation 3. Create joint research efforts. Develop a common research agenda for public health and medicine using a threefold approach. First, educate clinical and public health researchers about the advantages of joining and applying their knowledge in the formulation, design, and execution of research projects. Second, focus these projects on significant health issues. Third, promote public and private funding of research that encourages conceptual and institutional linkages between public health and medicine.

Recommendation 4. Devise a shared view of health and illness. Develop a conceptual framework that gives public health and medicine a common approach to health and illness. Specific implementation strategies might include: Creating a unified framework of health and illness for public health and medicine which would utilize a health-illness continuum and focus on adaptive responses to and interactions with the environment. Developing means of transmitting this knowledge to students and practitioners, and to health care organizations. Devising research projects to implement the approach to health and illness contained in the unified framework. Identifying policy implications of the unified framework of health and illness, and educating policy makers about them.

Recommendation 5. Work together in health care provision. Develop a framework, including standards and strategies, for integrating health promotion and prevention services

and activities into both the clinical and community settings. Specific implementation strategies might include: Reviewing the strengths and weaknesses of different approaches to integrating health promotion and prevention services into health care delivery systems, including the impact of public and private purchasing strategies, as they have evolved in various health care markets across the country. Surveying and evaluating the effectiveness of state and federal regulatory incentives designed to encourage maximum integration of community-wide public health practice into the delivery of health care services and medical practice. Reviewing, summarizing, and encouraging research on the costs and effectiveness of health promotion and disease prevention programs. Fostering public/private community-wide health promotion and public information efforts to create an environment which is supportive of public health and prevention services and strengthens their impact on improving overall health status. Developing a model package of prevention and health promotion services and activities (including information on "best" practice guidelines), which could be adopted by health plan companies, integrated delivery systems and practitioners. Promoting the development of a national standardized health information system that would integrate public health and health services data. Initiating collaborations between public and private organizations to assess and respond to the changing health needs of communities. Developing health promotion and disease prevention standards and performance measures to include in quality assurance programs for health plan companies, integrated delivery systems and other providers. Recommendation 6. Jointly Develop Health Care Assessment Measures. Synthesize the knowledge of medicine and public health to improve the quality, effectiveness, and outcome measures of health care. Specific implementation strategies might include: Developing better measurement, monitoring, and accountability indices for the use of practitioners, health care provider institutions, and policy-makers. Developing better methods and criteria to establish databases, sufficiently standardized so that they can be readily shared by investigators. Emphasizing the importance of a combined role for medicine and public health in evaluating and placing in perspective major technological advances such as molecular biological screening and gene therapy. Establishing networks and collaborative groups, identifying teaching, intern and extern sites, and synthesizing core training material to accomplish the above objectives. Recommendation 7. Translate Initiative Ideas Into Actions. Outline processes for translating substantive proposals from the Medicine/Public Health Initiative into successful actions. Specific implementation strategies might include: Establishing a national steering committee of organizations represented in the Initiative to develop and coordinate implementation strategies. Linking such a national committee to parallel local committees developed in states and

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report C
A-17

Subject: Updates to the MSS Internal Operating Procedures

Presented by: Christopher Libby, Chair

Referred to: MSS Reference Committee
(Karen Dionesotes, Chair)

INTRODUCTION

Since the creation of the Medical Student Section, the Governing Council has periodically found cause to review the Internal Operating Procedures (IOPs) to ensure that the operations of the section are consistent with the IOPs. The last comprehensive GC Report on the IOPs was at A-09 and both policy and operational changes to the MSS have taken place since A-09. For these reasons, the GC, in communication with your Councilors, performed a comprehensive review of the IOPs with the following goals in mind:

1. Bringing the IOPs in line with current practice; and
2. Reducing redundancy and maximizing clarity; and
3. Proposing changes that modernize section operations; and
4. Correcting errors and eliminating conflict.

The Governing Council concluded that a number of changes are needed to the MSS IOPs to achieve these goals. The majority of the changes have been done to reduce redundancy and to reflect how the section functions. However, your Governing Council does feel that some changes should be adopted for the betterment of the section. To make all the proposed changes clear, this report includes a section highlighting any changes that change MSS operations, a discussion of changes to each section, a detailed report on each change, and an appendix with a copy of the proposed new IOPs.

HIGHLIGHT OF NEW CHANGES

1. Councilors may run for Chair-elect
2. Reduced the campaign budgets from \$1500 to \$1000 and added language to specify when the Speaker's Ruling will come out.
3. Formalized the AMA Delegate and Alternate AMA Delegate as the credentialing authority of the Regional Delegates and Alternate Regional Delegates
4. Opened the MSS Caucus in the HOD up to all Delegates and Alternate Delegates who are MSS members
5. Added conflict of interest rules for Governing Council decisions.

DISCUSSION OF CHANGES

Section I: No changes

Section II: The MSS also promotes membership in organized medicine and works with other sections of the AMA. The principles have been updated to reflect this

Section III: No Changes

Section IV: Many of the changes to Section IV are to reflect how the Governing Council positions have evolved:

- A. Updated to reflect GC Resolution A at I-16
- B. The MSS does not function on a quarterly calendar and the language was changed to reflect the role the National Meetings play
- C. No Changes
- D. The roles of each Governing Council member was updated to reflect their real roles. Of note, the AMA Delegate and Alternate Delegate are explicitly outlined as the credentialing authority of the Region Delegates and Alternate Region Delegates and the administrators of the MSS resolution review process. Additionally, the listing order of the positions was changed to move non-voting members to the end of the list of GC members.
- E. Removed redundant language
- F. No changes
- G. Grammatical and formatting changes

Section V (Previously Section VII): Most changes are to consolidate all election rules into one section. The only other change was to reflect current processes.

- A. Changed the BOT written report to a report to the MSS Assembly to give the MSS BOT flexibility. All reportable BOT activities are recorded and available on the AMA website already.
- B. No changes
- C. Removed due to being redundant
- D. Removed due to being redundant

Section VI (Previously Section V): There are numerous changes to clarify the campaign rules and who can run for positions

- A. Added the Medical Student Trustee to this rule in lieu of a separate section.
- B. AMA Council members may run for Chair-elect. CLRPD Report B at I-05 proposed the

change that barred Councilors from running for Chair-elect. They felt that the two most compelling reasons for this were that the Chair-elect is a funded position that could go to another student and that they feared the responsibilities of Chair-elect are too great to be able to fully participate while also being a Councilor. The also report concluded that BOT elect does not have as significant a burden and did not examine the workload that committee chairs have who are allowed to run for Chair-elect. These concerns need to be weighed against benefits of allowing additional highly qualified students to serve the MSS. Since the GC no longer meets in person in January for a GC meeting as they did at that time, we do not find the role of Chair-elect to be onerous enough to preclude Council members from running.

- C. Added Medical Student Trustee to consolidate redundant policy
- D. (New) Added new rules governing candidate speeches.
- E. (Previously D) Updated campaign rules for the digital age and removed redundant policy. Clarified the Region endorsement policy allowing for remote voting in home regions. Reduced the maximum allowed expenditures on campaigns from \$1500 to "\$1000. A new clause was added to specify that the Speaker's Ruling will be made available the same day applications become available. Finally, the procedures for investigating campaign infractions were clarified to cover most scenarios.
- F. (Previously E): No changes
- G. (Previously F): Added Medical Student Trustee to the rules and clarified the roles during an appeal.

Section VII (Previously Section VI): Updated to reflect the occasional need for MSS Task Forces.

Section VIII: The major changes to this section are to clarify the role of the Region Delegation Chair, the management of Regional Delegates and Alternate Regional Delegates, and to ensure the Region Bylaws have a formal position in MSS IOPs.

- A.
 - 1. No Changes
 - 2. No Changes
 - 3. Language was clarified to be consistent with current region meetings. The communication between the Region GC and the Regional Delegates and Alternate Regional Delegate was clarified maintaining the role of the Regional Delegation Chair.
 - 4. Solidified the role of Region Bylaws over State Chairs and Regional Delegates.
- B.
 - 1. Added new language to clarify the role the AMA Delegate and Alternate AMA Delegate play in managing the Regional Delegates and Alternate Regional Delegates.
 - 2. Added language outlining the additional responsibilities the Regional Delegates and Alternate Regional Delegates have in the MSS.
 - 3. (Previously 1.) Removed redundant language.
 - 4. Added language for qualifications that previously was similar to MSS GC.
 - 5. (Previously 2.) Updated language to give preference to region bylaws in establishing eligibility for Regional Delegates candidates who did not submit on time and are from a

state with no candidates. Added language giving preference to candidates in a state who submitted their application on time. Added in a clarification for suspending eligibility requirements when there are too few candidates to fill the available positions. Also added in a timeframe for submitting applications for Regional Delegates and Alternate Regional Delegates who ran from the floor.

- C. Added language to dictate how vacancies and substitute Regional Delegates and Alternate Regional Delegates should be selected. These processes are consistent with AMA Bylaws and is similar to how the Residents and Fellows Section manages its sectional delegates.
- D. (Previously C) This clarifies the role of the regional delegation chair and removes responsibilities that conflict with other areas of the IOPs and MSS procedures.

Section IX. The changes in this section are primarily to clarify the roles and responsibilities of how the MSS Caucus currently functions. One major change is to open the MSS Caucus to all HOD Delegates and Alternate Delegates who are members of the MSS. Additionally, language clarifying the primacy of MSS Policy in guiding caucus positions is proposed.

- A. Most proposed changes are to clarify the roles in the MSS Caucus. The language barring MSS members who are delegates or alternate delegates, but not Regional Delegates or Alternate Regional Delegates is removed as noted above.
- B. Clarified that MSS policy must be followed in taking MSS Caucus positions
- C. Clarified the details needed in the AMA Delegate Report

Section X:

- A. Changed language to reflect meetings lasting longer than one day
- B. Shortened the time to disseminate information via the meeting handbook to 30 days from 90 days to reflect candidate and resolution deadlines elsewhere in the IOPs.
- C. Removed or updated outdated references to sections in the IOPs that no longer exist.
- D. Minor clarifications to the purpose of the MSS Assembly
- E. Clarified to whom applications for representation are sent.
- F. Removed voting privileges in the MSS Assembly from the Presiding Officer in all scenarios except to break a tie.
- G. Similar to X.B, the deadline to disseminate the agenda is changed to 30 days before the meeting from 21 days. This makes the dissemination of information consistent.
- H. Updated the reference committee language to reflect the Virtual Reference Committee. Also clarified the rules regarding Late and Emergency resolutions while removing unnecessary language.
- I. Clarified language around the committees to reflect the VRC and where the responsibilities of each committee's roles are enumerated in the IOPs.

Section XI:

- A. No changes
- B. No Changes
- C. Added rules regarding conflicts of interest when the Governing Council nominates individuals for AMA Councils or AMA Liaisons. Also removed the set time to notify applicants of their appointments because the MSS cannot dictate the BOT's schedule.

Section XII:

- A. Removed due to being redundant.
- B. Updated to reflect MSS leaders that may be funded by the section. The reporting period was also changed to “upon request” to reflect the actual practices of the MSS.

Section XIII: Removed reference to outdated section of the IOP.

Section XIV: Removed subsection A due to it being redundant with language elsewhere.

RECOMMENDATIONS:

RESOLVED, That our AMA-MSS amend IOP II.H by insertion and deletion as follows:

“**H.** Work cooperatively with other student groups and AMA Sections to meet these objectives.”; and be it further

RESOLVED, That our AMA-MSS amend IOP IV.B by insertion and deletion as follows:

“**Authority.** The Governing Council shall direct the programs and activities of the MSS. During the interval between meetings of the MSS Assembly, the Governing Council shall act on behalf of the MSS in formulating decisions related to the development, administration, and implementation of student activities, programs, goals, and objectives. The MSS shall be notified at ~~least quarterly~~ each National Meeting of actions taken by the Governing Council on its behalf.”; and be it further

RESOLVED, That our AMA-MSS amend IOP IV.D by insertion and deletion as follows:

Duties and Privileges. The Governing Council shall direct the programs and activities of the MSS, subject to the approval of such programs and activities by the Board of Trustees or House of Delegates of the AMA.

1. Chair. The Chair shall:
 - a. Preside at all meetings of the Governing Council, and otherwise represent the MSS when appropriate.
 - b. Preside at Assembly meetings if both the Speaker and Vice Speaker positions are vacant, until such time that successors to the Speaker or Vice Speaker may be elected.
 - c. Be the primary spokesperson for the MSS both inside the AMA and to outside organizations.
2. Vice Chair. The Vice Chair shall:
 - a. Preside at meetings of the Governing Council in the absence of the Chair or at the request of the Chair.
 - b. Assist the Chair in the performance of his or her duties.
 - c. Have the primary responsibility of coordinating the internal operations of the MSS including but not limited to the MSS standing and ad-hoc committees.
3. AMA Delegate and Alternate AMA Delegate. The AMA Delegate and Alternate AMA Delegate shall:
 - a. Represent the MSS in the AMA House of Delegates including credentialing of Region Delegates and Alternate Regional Delegates.
 - b. Serve as Chair and Vice Chair, respectively, of the MSS Caucus
 - c. Be responsible for forwarding resolutions from the MSS in the HOD and providing a summary of pertinent actions for the MSS on resolutions sent to the HOD.

- d. Administer the MSS resolution review process.
4. At-Large Officer. The At-Large Officer shall:
 - a. Perform such functions as determined by the Governing Council, and assist the other officers in the performance of their duties.
 - b. Coordinate the activities of the MSS Regions
- ~~5. Chair-elect. The Chair-elect shall be a non-voting member of the Governing Council. The Chair-elect shall assist the other officers in the discharge of their duties.~~
5. Speaker and Vice Speaker. The Speaker and Vice Speaker shall:
 - a. Preside over meetings of the MSS Assembly in an impartial manner, organizing and conducting them in accordance with The Standard Code of Parliamentary Procedure, AMA Bylaws, and MSS Internal Operating Procedures. The Vice Speaker shall officiate for the Speaker in the Speaker's absence or at the request of the Speaker.
 - b. Provide for oversight and enforcement of the Campaign Rules, including responsibility for investigation of alleged infractions and reporting of substantiated infractions to the Assembly prior to balloting.
 - c. Organize an orientation at each Assembly Meeting for new MSS Delegates and Alternate MSS Delegates to the Assembly.
 - d. Work with other members of the Governing Council in instructing the Convention Committees regarding their duties prior to each Assembly Meeting.
 - e. Refer resolutions and reports submitted for consideration at MSS Assembly meetings to reference committees.
 - f. Prepare a document summarizing parliamentary procedure used in Assembly meetings to be published in the MSS agenda book that is made available to each Assembly representative prior to Assembly meetings.
 - g. Review the MSS Digest of Actions for consistency with Assembly action prior to its annual posting to the AMA website.
6. Chair-elect. The Chair-elect shall be a non-voting, funded member of the Governing Council. The Chair-elect shall assist the other officers in the discharge of their duties.
7. Immediate Past Chair. The Immediate Past Chair shall be a non-voting, unfunded member of the Governing Council. ; and be it further

RESOLVED, That our AMA-MSS amend IOP IV.E by insertion and deletion as follows:

"D. Governing Council Terms.

1. The Chair-elect/Chair/Immediate Past Chair of the Governing Council shall serve a two-year term. His or her term as Chair-elect will begin at the conclusion of the Interim Meeting at which he or she is elected. He or she will take office as Chair at the conclusion of the following Annual Meeting, and one year later will become Immediate Past Chair. He or she will serve as Immediate Past Chair until the conclusion of the following Interim Meeting.
2. The other Governing Council members shall serve one-year terms, beginning at the conclusion of the Annual Meeting at which they are elected and ending at the conclusion of the next Annual Meeting of the AMA House of Delegates.
3. Maximum tenure for members of the MSS Governing Council will be two years in any combination of voting positions. "

RESOLVED, That our AMA-MSS amend IOP IV.G by insertion and deletion as follows:

"...Students deemed qualified by the other provisions of the AMA Bylaws and these Internal Operating Procedures for election to the positions of:

- MSS Governing Council, or
- The AMA Board of Trustees, or
- Appointment through the MSS to a position on an AMA Council, or

- ~~A~~ committee outside of the AMA that is national in scope and appointed by the Governing Council, the AMA President, the AMA President-elect or the AMA Board of Trustees (such as National Board of Medical Examiners, National Resident Matching Program, American Medical Association Political Action Committee, Liaison Committee on Medical Education, etc.)

shall be only so deemed if they have served three or fewer years in one or a combination of any of the aforementioned positions...”; and be it further

RESOLVED, That our AMA-MSS amend IOP VII by insertion and deletion as follows:

“VII. Medical Student Trustee

A. Duties and Privileges. A medical student member of AMA shall be elected annually by the MSS Assembly to serve as a member of the AMA Board of Trustees. The student member of the Board of Trustees shall ~~submit a written report of~~ on the Board’s activities to the Assembly before the Annual Meeting. This report will communicate Board Actions related to the concerns of the MSS and will provide the MSS with directives on behalf of the Board.

B. Term. The MSS Assembly shall elect the Medical Student Trustee at the Interim Meeting for a one-year term beginning at the close of the next AMA House of Delegates Annual Meeting and concluding at the close of the second AMA House of Delegates Annual Meeting following the meeting at which the member was elected.

~~**C. Limitation on Total Years of Service.** See MSS Internal Operating Procedure IV.G.~~

~~**D. Elections.**~~

- ~~1. Candidates. Medical students seeking the student position on the AMA Board of Trustees must submit an application, curriculum vitae, and statement of interest by the deadline determined by the Governing Council. Students who have submitted applications after the deadline may be nominated from the floor of the Assembly Meeting at a time determined by the Governing Council. Incumbent students seeking reelection must enter the election process.~~
- ~~2. Eligibility. MSS members who hold a position as a member of an AMA Council or as an AMA Liaison to a committee outside of the AMA that is national in scope are eligible to be candidates for the position of Medical Student Trustee at the Interim Meeting if their current AMA Council or AMA Liaison position will not continue past the Annual Meeting.~~
- ~~3. Nominations. Nominations for the Medical Student Trustee shall be received in advance of the Interim Meeting pursuant to the rules of the MSS. Further nominations may be made from the floor of the Assembly Meeting at a time determined by the Governing Council if the student has submitted a completed application.~~
- ~~4. Speeches. Candidates are allowed to address the Assembly for up to three minutes during a general Assembly session, as scheduled by the Governing Council. In addition, the Chair of the Governing Council, or his or her designee, shall ask each candidate a number of questions on issues of relevance during a general Assembly session, as scheduled by the Governing Council.~~
- ~~5. Campaign. Refer to MSS Internal Operating Procedures V.D. for the Code for Campaigning applicable to the Medical Student Trustee election.~~
- ~~6. Election Process.~~

- a. ~~Time. The election of the Medical Student Trustee shall occur during the voting period at the Interim Assembly Meeting of the MSS. The Governing Council shall set the day and time.~~
- b. ~~Method of Election. When there is only one candidate, election shall be by affirmation. All other elections shall be by ballot. The method of election shall be majority vote, that is, the candidate who has received the largest number of votes shall be elected if that nominee has received a majority of the legal votes cast. If no candidate receives a majority of the legal votes cast or there is a tie, a runoff election will be held between the two (or more if necessary because of a tie) candidates receiving the highest number of legal votes cast.~~
- c. ~~Processing. No ballots will be cast after the expiration of the voting period. The ballot boxes will be collected by members of the Rules Committee. The Rules Committee and the ballot boxes will be sequestered in a private location. At this time the Chair of the Rules Committee will open the ballot box and the Rules Committee will then count the ballots and tabulate the results. The candidate who has received the largest number of votes shall be elected if that nominee has received a majority of the votes cast. Upon completion of the tabulation, the Chair of the Rules Committee will validate the election results by determining that each ballot is official, that the number of ballots cast is equal to or less than the number distributed, and will then certify the results in writing. He or she will then immediately forward these results to the Assembly's Presiding Officer. Upon receipt of the Rules Committee's election results and verification, the Presiding Officer will announce the results to the Assembly provided there are no ties or runoff elections.~~
 - i. ~~First Ballot. The credentialed MSS Delegate will receive one initialed ballot from a designated member of the Credentials Committee at the credentials table during the set voting period.~~
 - ii. ~~Additional Ballot(s). If no candidate receives a majority of the legal votes cast or there is a tie, additional ballot(s) will be distributed by the Credentials Committee at the request of the Assembly's Presiding Officer. The candidate who receives a simple majority of the legal votes cast in the runoff election will be declared the winner.~~
- d. ~~Appeals. See MSS Internal Operating Procedures V.F.6.~~

RESOLVED, That our AMA-MSS amend IOP V by insertion and deletion as follows:

VI. Elections

- A. Time of Election.** The Chair-elect of the Governing Council and Medical Student Trustee shall be elected by the MSS Assembly at the Interim Meeting. The remaining Governing Council members, with the exception of the Immediate Past Chair, shall be elected by the MSS Assembly at the Annual Meeting of the MSS. The Governing Council shall set the day and hour of such elections and shall communicate the day and hour to the medical student members of the AMA prior to each Interim Meeting and Annual Meeting.
- B. Eligibility.** All members of the MSS are eligible to be elected to any office, except:
 - 1. ~~MSS members who hold a position as a member of an AMA Council or as an AMA Liaison to a committee outside of the AMA that is national in scope are not eligible to be candidates for a position on the MSS Governing Council at the Annual Meeting if their term as a member of an AMA Council or AMA Liaison will either begin after or continue more than two months past that Annual Meeting.~~

- ~~2. 1. MSS members who serve or will serve in an shall not hold an AMA Council or AMA Liaison position may not also serve or run to serve in as well as a Governing Council position or the Medical Student Trustee at the same time for more than two months, unless their Governing Council position will conclude before their term as a member of an AMA Council or AMA Liaison begins. The only exception shall be that a MSS member may hold an AMA Council or AMA Liaison position and the position of Chair-elect or Immediate Past Chair simultaneously.~~
- ~~3. MSS members may not run for the position of Chair-elect while simultaneously serving as a member of an AMA Council or AMA Liaison.~~

C. Nominations. Nominations for Governing Council positions shall be received in advance of the Annual Meeting (in advance of the Interim Meeting for the Chair-elect and Medical Student Trustee), pursuant to the rules of the MSS. Further nominations may be made from the floor of the Assembly Meeting at a time determined by the Governing Council.

D. Speeches. Candidates are allowed to address the Assembly for a period of time determined by the Speakers up to a maximum of three minutes during a general Assembly session, as scheduled by the Speakers. In addition, the Chair of the Governing Council, or his or her designee, shall ask each candidate a number of questions on issues of relevance during a general Assembly session, as scheduled by the Speakers.

ED. Campaign Rules.

1. Candidacy. All MSS members shall be considered potential candidates for all elected offices and shall be bound by all Campaign Rules during the election cycle for each office, where the election cycle for an office is defined as the time between elections for that office.
2. Campaign Period.
 - a. Campaigns shall be run only for positions that are electable at the present meeting.
 - b. Between meetings, campaigns shall be run only for positions that are electable at the upcoming meeting.
 - c. The official campaign period shall be defined as starting the first day applications are made available for MSS members to submit their candidacy
 - ~~e.d.~~ All activities related to announcement of candidacy, endorsement, or campaigning, including but not limited to distribution of materials, communications, and speaking opportunities shall be limited to the campaign period defined above.
- 3. Speaker's Ruling. A Speaker's Ruling for the each national meeting and election will be made available to all potential candidates at the start of the campaign period with a document of rulings so that all candidates have equal access to all rules relating to their campaigns. Once released, the MSS Speakers' reserve the right to issue addendums or announcements during the campaign period as needed
- ~~3.~~ 4. Candidate Disclosure Form.
 - a. The day before the election is scheduled to occur, all candidates nominated, either in advance of the meeting or from the floor at the meeting, shall submit a completed Candidate Disclosure Form to the Speaker, the Vice Speaker, or a member of the Rules Committee no later than the time of day designated by the Speaker. No candidate shall be elected if he or she has not completed and submitted a Candidate Disclosure Form.
 - b. The Candidate Disclosure Form shall be prepared by the Speaker and Vice Speaker and shall consist of three parts:

- i. A portion, completed by the candidate, for disclosure of campaign leadership and campaign finances.
 - ii. A portion, completed by the candidate, affirming that the candidate has read the IOP sections relevant to campaigning and the Speakers' Rulings for that election cycle and agrees to abide by the rules and recommendations contained within those documents.
 - iii. A portion, completed by the Speaker or Vice Speaker, for disclosure of any prior, substantiated infraction(s) of MSS IOPs by the individual declared as a candidate.
4. 5. Candidates may distribute only the following campaign materials:
 - a. Buttons, stickers, and pins less than 2.5 inches in greatest dimension.
 - b. Standard-size business cards.
 - c. Curricula vitae and personal statements.
 - i. Curricula vitae and personal statements of candidates nominated, pursuant to the rules of the MSS, in advance of the national meeting at which the election will be held shall be included in the online version of the MSS Meeting Handbook.
 - ii. At the Assembly Meeting, distribution of curricula vitae and personal statements shall be limited to the area and medium/media designated by the Speaker and announced at least 30 days prior to the meeting at which the election will be held.
 - iii. While there will be no limit on the length of curricula vitae, personal statements will be limited to one page (front and back).
 - d. No trinkets, candy, pens, or other items may be displayed or distributed.
5. 6. The total expenditure per candidate per campaign shall not exceed ~~\$1,500~~ \$1000, including all monetary donations and in-kind donations of goods, but not including the candidate's travel to and lodging at the meeting at which the election is held.
6. 7. Campaign Communications.
 - a. Advance non-electronic mailings by candidates or other organizations on behalf of a candidate are not permissible.
 - b. Candidates should be prudent and courteous regarding the number and content of electronic messages, including but not limited to email, social media ~~profiles~~, phone, text message, and group chats, sent prior to the election.
 - c. ~~Candidates should use discretion in the number and length of phone calls and text messages made prior to the election.~~
 - ~~d.c.~~ No mode of MSS- or AMA-sponsored communication, including but not limited to listservs, phone or email lists, or other mass communication methods shall be used for announcements of candidacy, endorsement, or campaigning.
 - d. Candidates using campaign-specific social media accounts can only invite MSS members to follow said accounts.
6. 8. Campaigning at MSS Regional, state, or school section meetings prior to the meeting at which the election occurs, including ~~attendant~~ attending social events, is prohibited. The candidate's own MSS Region, state, or school section meetings are an exception to this rule. Campaigning includes, but is not limited to, discussing candidacy or displaying or distributing campaign paraphernalia.
7. 9. Campaign Involvement.
 - a. Only MSS members may be involved in a candidate's campaign. MSS members should not share their opinion in favor of or in opposition to any candidate while acting under any official leadership role within or outside of the organization.
 - i. Exception: Candidates may wear their own campaign paraphernalia at all times during the Assembly Meeting at which their election is held

- b. The campaign involvement of AMA staff members, members of the MSS Governing Council, and members of the MSS Rules Committee shall be limited to candidate inquiries regarding election-related matters and AMA-related information so long as that information is made available to all MSS members who request it.
- ~~c. No person communicating by any medium in his or her official role as a national or regional-level leader of the MSS may discuss or promote any candidacy during that communication.~~
 - ~~iii. Exception: Candidates may wear their own campaign paraphernalia at all times during the Assembly Meeting at which their election is held.~~
- ~~d.c.~~ The following public endorsements are permitted:
 - i. One (1) optional letter of endorsement by the Dean or Dean's representative from the medical school that the candidate is enrolled in; and one (1) optional letter of endorsement by staff of the state society from the state where the candidate attends medical school are permitted.
 - 1. These optional letters of endorsement may be included in the Election Manual and may be displayed on social media.
 - 2. During a national meeting, these letters may only be publicly disseminated via the Election Manual and may only be publicly displayed at the candidate forum.
 - ii. One (1) optional letter of endorsement ~~by each MSS Region is permitted by vote.~~ and a verbal endorsement by each candidate's MSS Region where their school resides is permitted by vote within the campaign period.
 - 1. The endorsing Region must:
 - a. Follow the Region's bylaws regarding issuance of public endorsement;
 - i. If a Region does not have bylaws specifying quorum or rules dictating official support, the Region must contact the Speakers for guidance.
 - b. Document that quorum was met when the voting occurred; and
 - c. Document the results of the vote pursuant to Region bylaws.
 - 2. The optional letter of endorsement will not be included in the Election Manual but may be displayed on social media.
 - 3. During a national meeting, such endorsement may not be publicly disseminated nor displayed except as on social media.
 - ~~4. When speaking in official support of a candidate on behalf of an MSS Region, MSS Region Chairs must be sure that an official vote by the Region took place in accordance with the Region's bylaws for quorum and rules dictating official support and document that vote.~~
 - ~~d. If a Region does not have bylaws specifying quorum or rules dictating official support, the Region must contact the Speakers for guidance.~~
 - ~~e. Regions may not vote to take an official stance prior to the meeting at which elections will occur, with the exception being Regions where candidates attend medical school.~~
 - ~~f. Regions may not vote to oppose any candidate.~~

- iii. A verbal endorsement of a candidate whose medical school is outside the endorsing region is permissible only at the meeting at which an election is taking place.
 1. The endorsing Region must:
 - a. Follow the Region's bylaws regarding issuance of public endorsement;
 - i. If a Region does not have bylaws specifying quorum or rules dictating official support, the Region must contact the Speakers for guidance.
 - b. Document that quorum was met when the voting occurred; and
 - c. Document the results of the vote pursuant to Region bylaws.
 2. When speaking in official support of a candidate on behalf of an MSS Region, MSS Region Chairs must be sure that an official vote by the Region took place in accordance with the Region's bylaws for quorum and rules dictating official support and document that vote.
 3. Regions may not vote to oppose any candidate.
9. 10. Candidates must be allowed to fully participate in candidate interviews and question and answer sessions during the Assembly Meeting.
10. 11. At the national meeting at which the election is taking place, a group that invites any candidate for a particular office to speak must invite and make a reasonable effort to accommodate all candidates for that office. Candidates may choose at their discretion to attend or not or may send a representative to speak for them, but any candidate's availability or lack thereof shall not impose a restriction on the attendance of other candidates.
11. 12. Receptions and/or hospitality shall not be used for promotion of candidates.
12. 13. Enforcement.
 - a. Alleged infractions, including but not necessarily limited to violations of the Campaign Rules, should be reported in writing to the MSS Speaker or Vice Speaker, or to any member of the MSS Rules Committee.
 - b. The Speaker and Vice Speaker, shall be the investigators of any alleged infraction in conjunction with the Rules Committee, shall be responsible for investigating alleged infractions. No person who is a candidate in the same election as the candidate being investigated for alleged infractions may participate in any part of the investigation of those alleged infractions. The candidate is required to participate in the investigation.
 - i. In the event where both the Speaker and Vice Speaker are candidates for the election being investigated, the MSS Chair will designate a member of the Rules Committee as investigator to examine the alleged infraction.
 - c. Following their investigation, the MSS Speaker or Vice Speaker investigator shall inform the alleged violator of the infraction in writing, including the results of the investigation of the alleged infraction. The alleged violator shall be offered an opportunity to rebut the alleged infraction. Following rebuttal, the MSS Speaker or Vice Speaker investigator shall determine whether the alleged infraction is substantiated and shall report his or her finding in writing to the alleged violator.
 - d. Following their investigation and the alleged violator's opportunity to rebut the alleged infraction and prior to balloting, the MSS Speaker or Vice Speaker investigator shall report substantiated infractions to the Assembly but shall not

~~make any recommendation to the Assembly. No person who is a candidate in the same election as the candidate whose infractions have been substantiated may participate in any part of the reporting of those infractions to the Assembly. In the event that both the Speaker and Vice Speaker are candidates in elections in which campaign rule violations have been alleged, a member of the Rules Committee shall report substantiated infractions in that election to the Assembly but shall not make any recommendation to the Assembly.~~

- e. Enforcement of a campaign infraction shall follow a systematic approach. Each candidate, upon each substantiated infraction of the Campaign Rules, shall be given an official warning letter from the Speaker. Exceeding three (3) substantiated infractions during a campaign shall render a candidate ineligible for election during that campaign period.

F. E. Voter Eligibility. Credentialed MSS members acting as MSS Delegates for the meeting will be eligible to vote.

G. F. Method of Election.

1. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.
2. Voting Periods. There shall be one voting period at the Interim Meeting for the selection of the Chair-elect and Medical Student Trustee. There shall be one voting period at the Annual Meeting for the selection of the Vice Chair, AMA Delegate, At-Large Officer, and Speaker. An additional balloting period will be held for the elections of Alternate AMA Delegate and Vice Speaker.
3. First Ballot. At the Interim Meeting, one ballot shall be used by the credentialed MSS Delegate to cast one vote for the Chair-elect and Medical Student Trustee. At the Annual Meeting, individual ballots for each position shall be used by the credentialed MSS Delegate to cast one vote for each of the four positions: the Vice Chair, AMA Delegate, At-Large Officer, and Speaker. No ballot shall be counted if there is more than one vote for a position. All Governing Council positions will be determined by majority vote, that is, the candidate who has received the largest number of votes shall be elected if that nominee has received a majority of the legal votes cast.
 - a. Election of Alternate AMA Delegate. After the election of the AMA Delegate, all unsuccessful candidates who were nominated for the office of AMA Delegate may be added to the existing Alternate AMA Delegate ballot by nomination from the floor of the Assembly. Each MSS Delegate to the Assembly Meeting who is present at the meeting may cast a written ballot for the election of the Alternate AMA Delegate from the previously declared candidates and among those so nominated. Election to the office of Alternate AMA Delegate requires a majority of the legal votes cast.
 - b. Election of Vice Speaker. After the election of the Speaker, all unsuccessful candidates who were nominated for the office of Speaker may be added to the existing Vice Speaker ballot by nomination from the floor of the Assembly. Each MSS Delegate to the Assembly Meeting who is present at the meeting may cast a written ballot for the election of the Vice Speaker from the previously declared candidates and among those so nominated. Election to the office of Vice Speaker requires a majority of the legal votes cast.
4. Runoff Election. If no candidate receives a majority of the legal votes cast or there is a tie, a runoff election will be held between the two (or more if necessary because of a tie) candidates receiving the highest number of legal votes cast.

5. Processing. No ballots will be cast after the expiration of the voting period. The ballot boxes will be collected by members of the Rules Committee. The Rules Committee and the ballot boxes will be sequestered in a private location. At this time, the Chair of the Rules Committee will open the ballot boxes and the Rules Committee will then count the ballots and tabulate the results. The candidate who has received the largest number of votes shall be elected if that nominee has received a majority of the legal votes cast. Upon completion of the tabulation, the Chair of the Rules Committee will validate the election results by determining that each ballot is official, that the number of ballots cast is equal to or less than the number distributed and will then certify the results in writing. He or she will then immediately forward these results to the Assembly's Presiding Officer. Upon receipt of the Rules Committee's election results and verification, the Presiding Officer will announce the results to the Assembly.
 - a. First Ballot. The credentialed MSS Delegate will receive one initialed ballot from a designated member of the Credentials Committee at the credentials table during the set voting period.
 - b. Runoff Election. If no candidate receives a majority of the legal votes cast or there is a tie, additional ballot(s) will be distributed by the Credentials Committee at the request of the Assembly's Presiding Officer. The candidate who receives a majority of the legal votes cast in the runoff election will be declared the winner.
6. Appeals. Appeals of the election process and results must be made in writing to the Assembly's Presiding Officer no later than one hour after the official announcement of the final results.
 - a. Any appeal of the process of ballot(s) distribution, ~~as outlined in MSS Internal Operating Procedures V.F.3.,~~ will be considered by the Rules Committee. Consideration of such appeals and merits of said appeals will be determined in whatever manner the committee deems necessary. The results of the committee's recommendations must be forwarded in writing by the Committee Chair to the Assembly's Presiding Officer.
 - b. Any appeal of the process of ballot processing, tabulation, and announcement of results, ~~as outlined in 4 MSS Internal Operating Procedures V.F.5.,~~ shall be considered by the Credentials Committee ~~in the same manner as outlined in MSS Internal Operating Procedures V.F.6.a.~~ Consideration of such appeals and merits of said appeals will be determined in whatever manner the committee deems necessary. The results of the committee's recommendations must be forwarded in writing by the Committee Chair to the Assembly's Presiding Officer.-
 - c. No person who is a candidate in the election being appealed may participate in any part of the appeals process.
 - d. The Assembly's Presiding Officer and the ~~preceding~~ Governing Council ~~at the Annual Meeting or the present Governing Council at the Interim Meeting~~ will consider the appeals report(s) from the Committee(s) dealing with the matter. Final decision on the election results will be the jurisdiction of the Governing Council ~~as described above.~~ “

RESOLVED, That our AMA-MSS amend IOP VI by insertion and deletion as follows:

”VII. MSS Standing Committees

The MSS Standing Committees and Task Forces shall be appointed by the Governing Council and shall support the mission of the MSS as outlined in MSS Internal Operating Procedures.” ; and be it further

RESOLVED, That our AMA-MSS amend IOP VIII by insertion and deletion as follows:

“VIII. Regions

A. Structure and Purpose of the MSS Regions.

1. There are seven Medical Student Regions defined for the purposes of electing Regional Delegates to the AMA House of Delegates from Medical Student Regions. The regions are:
 - Region 1: Washington, Oregon, California, Nevada, Utah, Colorado, Arizona, New Mexico, Montana, North Dakota, South Dakota, Idaho, Wyoming, Alaska, Hawaii.
 - Region 2: Minnesota, Wisconsin, Nebraska, Iowa, Missouri, Illinois.
 - Region 3: Kansas, Texas, Oklahoma, Arkansas, Louisiana, Mississippi.
 - Region 4: Florida, Georgia, Alabama, South Carolina, North Carolina, Tennessee, Puerto Rico.
 - Region 5: Michigan, Indiana, Ohio, Kentucky, West Virginia.
 - Region 6: Virginia, Maryland, District of Columbia, Delaware, New Jersey, Pennsylvania.
 - Region 7: Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New York
2. In addition to providing a structure for election of Regional Delegates, the MSS defines the roles of the regions as follows: to provide a home within the MSS, to serve as a communication unit for the MSS, to provide a means to foster collaboration between the sections and states, and to facilitate interaction and integration of newly developing sections with well-established sections.
3. Each region shall be governed by a Regional Chair to be elected in accordance with the region’s bylaws. The Regional Chair will serve as the liaison for their respective region to the Governing Council. Other regional officer positions may be elected in accordance with the region’s bylaws. The role of the Regional Chair is as follows:
 - a. Encourage the organization of regional conferences as effective mechanisms of increasing communication among its members.
 - b. Encourage the development of local MSS sections in educational programs accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA) where local sections do not exist and the development of state MSS sections in states where they do not exist.
 - c. Involve highly organized MSS sections and state sections in providing organizational information and assistance to developing sections.
 - d. Encourage MSS sections to maintain communication and interaction between medical student members and physician members of state associations and component societies.
 - e. ~~Endorse the maintenance of active and timely communication between Regional Delegates and Regional Chairs.~~
4. Each region shall have a Region Governing Council, which will be composed of the Region Chair, other elected or appointed officers of the region consistent with that region’s regional bylaws and at the discretion of the Regional Chair, ~~the State Chairs, and the Regional Delegates in each region.~~ The purpose of the Region Governing Council shall be to further ~~improve communication within our regions by enhancing regional-state ties and providing each Region Chair with the most accurate understanding of his or her region's views on particular issues.~~ fulfill the purpose of each region as defined both in the MSS Internal Operating Procedures and the region’s bylaws.-

B. Regional Delegates to the AMA House of Delegates.

1. Regional Delegates and Alternate Regional Delegates are part of the MSS Caucus led by the AMA Delegate and Alternate AMA Delegate. Credentialing of Regional Delegates and Regional Alternate Delegates is under the purview of the AMA Delegate and AMA Alternate Delegate.
2. MSS Responsibilities: The Regional Delegates and Alternate Regional Delegates will serve as mentors in the MSS and assist the AMA Delegate and Alternate AMA Delegate in reviewing MSS resolutions.
- 3.1- Apportionment and Seating. Each Medical Student Region is entitled to Regional Delegate and Alternate Regional Delegate representation based on the number of seats allocated to it by apportionment, as outlined in AMA Bylaw 2.3.2. ~~An elected Regional Delegate will be seated with the state delegation from the jurisdiction in which his or her educational program is located.~~
 - a. If a Regional Delegate cannot fulfill his or her duties, the Alternate Delegate shall assume the position of Regional Delegate and be seated with the state in which the Regional Delegate's educational program is located.-
4. Qualifications. Each candidate for Regional Delegate or Alternate Regional Delegate must meet the following minimum qualifications:
 - a. Any medical student member of the AMA is eligible for a Regional Delegate or Alternate Regional Delegate position, except as prohibited by AMA Bylaws, MSS IOPs, or Region bylaws.
 - b. All elected Regional Delegates and Alternate Regional Delegates must attend a medical school in the region in the region they are elected to represent.
- 5.2- Elections. The MSS will elect Regional Delegates and Alternate Regional Delegates to the AMA House of Delegates according to the following guidelines:
 - a. Each Medical Student Region is responsible for selecting its own Regional Delegate(s) and Alternate Regional Delegate(s), based on the process identified ~~by the region and submitted to the MSS Governing Council by the close of each Annual Meeting. in each region's bylaws.~~
 - b. Elections for the Regional Delegates and Alternate Regional Delegates to the AMA House of Delegates will be held at the Interim Meeting of the MSS. Each Region must submit the name(s) of its newly-elected Regional Delegate(s) and Alternate Regional Delegate(s) to the MSS Governing Council before the close of the Interim Meeting.
 - ~~c. Qualifications for candidates will be the same as those for MSS Governing Council members as outlined in MSS Internal Operating Procedures IV.C.~~
 - c.d. Candidates will be required to submit a completed application and curriculum vitae to the Department of Medical Student Services including the written endorsement of the state association in which their educational program is located and curriculum vitae to the Medical Student Section staff by the published deadline each year to be kept on file by the Department of Medical Student Services Medical Student Section.
 - i. This provision may only be suspended if there are more Regional Delegate or Alternate Regional Delegate positions available than applicants who submitted on time or if there is a state in the region without an applicant.
 1. Applicants who do not submit their materials by the established application deadlines may be considered for available seats, but only after applicants who submitted their applications on time have been considered.

2. Each region will determine whether or not to consider a candidate running from the floor from a state with no candidates who submitted on time simultaneously or after candidates from states with applicants who submitted on time.
- ii. An RD/AD who is elected from the floor without having submitted the application materials by the deadline must submit such materials within 60 days of the election in order to retain the position.
- ~~d. To be eligible for election, a medical student member must receive the written endorsement of the state association with which he or she would be seated if elected to the position of Regional Delegate.~~
- ~~e.d.~~ Each state is entitled to a maximum of one Regional Delegate, unless there are fewer candidates than available positions or another state does not have a candidate that submitted their application on time. A state may have an unlimited number of Alternate Regional Delegates up to the maximum number of Regional Delegates.
- ~~e.f.~~ Medical Student Regional Delegates and Alternate Regional Delegates to the AMA House of Delegates are elected for one-year terms.
- ~~f.g.~~ All election disputes will be referred to the Governing Council.
- ~~g.h.~~ Each Region shall be free to institute more stringent requirements consistent with all other AMA and MSS rules.

C. Replacing Regional Delegates and Alternate Regional Delegates

1. Vacancies

- a. If vacancy in a Regional Delegate position is known, the Region Delegation Chair shall be responsible for nominating a replacement Regional Delegate from the Alternate Regional Delegates in the same region as the Regional Delegate that they are replacing in accordance with the region's bylaws at least 30 days prior to the meeting. All Regional Delegate replacements shall be approved at the discretion of the AMA Delegate and Alternate AMA Delegate. The replacement will serve the remainder of the Regional Delegate's Term per AMA Bylaw B-2.3.6.
- b. If vacancy in an Alternate Regional Delegate position is known, the Region Delegation Chair shall be responsible for nominating a replacement Alternate Regional Delegate from the same region as the Alternate Regional Delegate that they are replacing in accordance with the region's bylaws at least 30 days prior to the meeting. All Alternate Regional Delegate vacancies shall be approved at the discretion of the AMA Delegate and Alternate AMA Delegate. The replacement will serve the remainder of the Alternate Regional Delegate's Term per AMA Bylaw B-2.3.6.

2. Substitutes

- a. When a Regional Delegate or Alternate Regional Delegate is unable to attend a meeting of the House of Delegates, the AMA Delegate or AMA Alternate Delegate may appoint a substitute Regional Delegate or Alternate Regional Delegate, who on presenting proper credentials shall be eligible to serve as such Regional Delegate or Alternate Regional Delegate in the House of Delegates at that meeting consistent with AMA Bylaw B-2.10.4
 - i. All attempts will be made to work with the Region Delegation Chair of the region whose Regional Delegate or Alternate Regional Delegate is being replaced to find a student from the same region, but the position may be filled by a student from another region if no willing student from the same region can be found.

D.C. Creation of Regional Delegations to the House of Delegates. Through a mechanism of its own choosing, each Medical Student Region should appoint a member of its regional

delegation to the House of Delegates, either a Regional Delegate or an Alternate Regional Delegate, to serve in the capacity of Regional Delegation Chair. The responsibilities of the Regional Delegation Chair should include:

1. ~~Assign Regional Delegates to different Reference Committees.~~
 2. ~~1. Identify Regional Delegates and Alternate Regional Delegates who may be absent and suggest replacements in accordance with the MSS IOPs and the Region Bylaws. Coordinate the replacement of absent Regional Delegates with present Alternate Regional Delegates.~~
 3. ~~2. Take attendance of the Regional Delegates and Alternate Regional Delegates from their region at House of Delegates meetings.~~
 4. ~~Execute the region's plan to select a replacement Regional Delegate.~~
 5. ~~3. Mentor and orient inexperienced Regional Delegates.~~
 6. ~~4. Fulfill any other responsibilities assigned by the region.~~
5. Coordinate resolution authorship in the region for the MSS Assembly.“ ; and be it further

RESOLVED, That our AMA-MSS amend IOP IX by insertion and deletion as follows:

"IX. MSS Caucus to the HOD

A. MSS Caucus Structure

1. ~~The regional delegates and alternate regional delegates, together with the MSS Delegate and Alternate, form the MSS Caucus.~~ The MSS Caucus is comprised of the following members: The AMA Delegate and Alternate AMA Delegate; the Regional Delegates and Alternate Regional Delegates; any MSS member serving as a Delegate or Alternate Delegate on a state delegation; and any MSS member serving as a Delegate or Alternate Delegate on a specialty society delegation.
2. The MSS Delegate and MSS Alternate Delegate shall be considered the chair and vice chair of the caucus respectively and their responsibilities in those positions include, but are not limited to:
 - a. Overseeing debate, discussion, and voting that occurs within the caucus.
 - b. Assigning Rregional Ddelegates or Alternate Regional Delegates to serve on ad hoc caucus reference committees.
 - c. Speaking on behalf of the MSS in reference committee hearings and the HOD or delegating the responsibility to speak on certain resolutions and/or reports to others of their choosing.
 - d. Developing general MSS strategy for supporting or opposing resolutions and/or reports.
 - e. Coordinating and negotiating with the leadership of other groups within the HOD.
3. ~~Other medical student delegates to the AMA-HOD, including students appointed to their state delegations, are not considered members of the caucus for voting purposes, though they are encouraged to take part in MSS Caucus meetings and may be assigned to speak~~

~~on behalf of the MSS by the MSS Delegate.~~

B. Determining MSS Caucus Positions on AMA HOD Resolutions

1. For all MSS Caucus activities requiring a vote, all members of the caucus shall be given one vote.
2. A quorum of at least one half of potential voting members must participate for a vote to be valid.
3. In the AMA HOD, the MSS Caucus must take positions on resolutions that are consistent with the existing policy of the MSS as defined in the MSS Digest of Actions whenever ~~possible~~ relevant MSS policy exists.
4. In areas where relevant MSS policy exists, but the interpretation is uncertain, a majority vote of a quorum of delegates will determine the caucus's interpretation.
5. When a resolution is before the AMA HOD that is of significant importance to the MSS, but for which no MSS policy exists, any member of the MSS Caucus may move that the MSS take a position on the resolution. Such a movement requires a second by another caucus member and a 2/3rds majority vote to pass.
6. Positions set using the procedures described in section IX.B.5 are valid for the duration of that meeting only and do not apply to future interim or annual meetings.
7. The MSS Caucus may not ~~use the procedures described in section IX.B.5~~ to take positions that are contrary to existing MSS policy.

C. Reporting of Caucus Actions. The ~~MSS~~ AMA Delegate and Alternate AMA Delegate shall be responsible for authoring a report of actions taken, which shall be presented to the MSS Assembly at the next national meeting. This report will list the resolved clauses of all AMA HOD resolutions for which the MSS took a position, and will specifically identify those resolutions for which the MSS Caucus took a position that was not grounded in existing internal policy. "; and be it further

RESOLVED, That our AMA-MSS amend IOP X by insertion and deletion as follows:

"X. MSS Assembly Meeting

A. Date and Location. There shall be an Assembly Meeting of medical student members of the AMA (MSS) held ~~on a day~~ prior to each meeting of the AMA House of Delegates at a time and place fixed by the Executive Vice President of the AMA.

B. Call to the Meeting. ~~Ninety~~ Thirty days prior to the meeting, notice shall be sent to all medical students and medical student organizations detailing the time, place, credentialing process, resolution mechanisms, election procedures, and education programs for the meeting.

C. Representatives to the Assembly Meeting.

1. Educational Programs.
 - a. Central Campuses. The AMA medical student members of each educational program as defined in AMA Bylaw 1.1.1 (a "central campus") may select one MSS Delegate and one Alternate MSS Delegate. An educational program as defined in AMA Bylaw 1.1.1 that has a total medical student population (excluding students assigned to associated satellite campuses as defined in MSS Internal Operating Procedure ~~IX~~.C.1.b.) greater than 999, as determined by the AMA on January 1 of each calendar year, may select one additional MSS Delegate and one additional Alternate MSS Delegate.

- b. Satellite Campuses. The AMA medical student members of an educational program as defined in AMA Bylaw 1.1.1 that has more than one campus (a “satellite campus”) may select one MSS Delegate and one Alternate MSS Delegate from each campus. A satellite campus is defined as an administrative campus separate from the central campus where a minimum of 20 members of the student body are assigned for some portion of their instruction over a period of time not less than an academic year. MSS Delegates and Alternate MSS Delegates credentialing under the satellite campus provisions must, at the time of the meeting, reside at the campus they will represent.
 - i. A request to seat an MSS Delegate from a satellite campus for the first time must be submitted to the AMA Department of Medical Student Services at least 90 days in advance of the first Meeting at which an MSS Delegate will be seated. The request must confirm that the satellite campus meets the requirements for representation set forth in MSS Internal Operating Procedure ~~IX~~.C.b. and in AMA Bylaw 7.3.3.2.
 - c. Certification. Educational program MSS Delegates and Alternate MSS Delegates shall be certified to the Governing Council of the MSS by either a student officer of the educational program or a State Medical Student Section (~~as defined in MSS Internal Operating Procedure XI.C.~~), where it exists.
2. National Medical Specialty Societies, Federal Services, and Professional Interest Medical Associations.
- a. Eligibility. The following criteria have been developed for national medical specialty societies, federal services, and professional interest medical associations to qualify for representation in the MSS Assembly. Pursuant to AMA Bylaw 7.3.3.3, a national medical specialty society, federal service, or professional interest medical association must:
 - i. Have voting representation in the AMA House of Delegates.
 - ii. Allow for medical student membership.
 - iii. Have established a mechanism that allows for the regular input of medical student views into the issues before the organization.
 - b. A national medical specialty society, federal service, or professional interest medical association that satisfies these criteria may select one MSS Delegate and one Alternate MSS Delegate. MSS Delegates and Alternate MSS Delegates selected from national medical specialty societies, federal services, or professional interest medical associations must meet the following requirements:
 - i. Must be medical student members of the AMA in good standing.
 - ii. Should be chosen in a fair and equitable manner allowing open representation and medical student input.
 - iii. Must be certified in writing by the president, or appropriate staff person, of the organization they will be representing.
 - iv. Must represent the interests of their organization’s medical student constituency.
 - c. Application Process. An application will be provided to interested national medical specialty societies, federal services, and professional interest medical associations. The organization should submit the application form, and any other documents demonstrating compliance with these criteria, to the MSS Governing Council at least ninety days prior to the first Meeting at which they wish to seat an MSS Delegate. Upon approval by the Governing Council, the organization will be

granted a seat in the MSS Assembly with voting privileges on all matters except elections. The newly seated organization will be placed on probationary status for a period of two years, during which time consistent attendance at the four national Assembly Meetings is expected. At the conclusion of this probation period, the MSS Delegate selected by the organization will attain full voting privileges, including elections, and will be eligible to run for office. The Governing Council will notify the organization of its status at the end of the probation period.

- d. Biennial Review. Each national medical specialty society, federal service, or professional interest medical association represented in the MSS Assembly will be required to reconfirm biennially that it continues to meet the criteria for representation. Organizations will be notified by the Governing Council of the time of their review and will be asked to submit appropriate documentation. Failure to participate in the biennial review process or to meet the established criteria will be reported to the MSS Governing Council for action.
- e. The Governing Council may terminate the representation of an organization in the MSS Assembly for failure to verify fulfillment of or to meet these criteria, in which case the organization can reapply for representation ~~as outlined in MSS Internal Operating Procedure IX.C.2.c.~~

3. National Medical Student Organizations.

- a. The following criteria have been developed for national medical student organizations to qualify for representation in the MSS Assembly, pursuant to AMA Bylaw 7.3.3.4.1:
 - i. The organization must be national in scope.
 - ii. A majority of the voting members of the organization must be medical students enrolled in educational programs as defined in AMA Bylaw 1.1.1.
 - iii. Membership in the organization must be available to all medical students, without discrimination.
 - iv. The purposes and objectives of the organization must be consistent with the AMA's purposes and objectives.
 - v. The organization's code of medical ethics must be consistent with the AMA's Principles of Medical Ethics.
- b. Application process. Interested national medical student organizations should submit to MSS staff a written application containing sufficient information to establish that the organization meets the above criteria. The application must also include the following:
 - i. The organization's charter, constitution, bylaws, and code of medical ethics.
 - ii. A list of the sources of the organization's financial support, other than the dues of its medical student members.
 - iii. A list or description of all of the organization's affiliations.
 - iv. Such additional information as may be requested.

The MSS Governing Council shall review the application. If it recommends that the organization be granted representation in the MSS Assembly Meeting, the recommendation shall be submitted to the AMA Board of Trustees for review. If approved by the AMA Board of Trustees, the organization may be represented in the MSS Assembly Meeting by one MSS Delegate and one Alternate MSS Delegate.

- c. Biennial Review. Each national medical student organization represented in the MSS Assembly will be required to reconfirm biennially that it continues to meet

the criteria for eligibility by submitting such information and documentation as may be required by the MSS Governing Council. Organizations will be notified by the Governing Council of the time of their review and will be asked to submit appropriate documentation. Failure to participate in the biennial review process or to meet the established criteria will be reported to the MSS Governing Council for action.

- d. The Governing Council may recommend discontinuance of the representation by a national medical student organization on the basis that the organization fails to meet the above criteria, has failed to maintain its responsibilities outlined in these Internal Operating Procedures, or has failed to attend the MSS Assembly Meeting. The recommendation shall be submitted to the AMA Board of Trustees for review. If approved by the AMA Board of Trustees, the representation of the national medical student organization in the MSS Assembly Meeting shall be discontinued.
 - e. The MSS Delegate and Alternate MSS Delegate selected by each national medical student organization granted representation at the Assembly Meeting shall:
 - i. Have full voting rights including the right to vote in any elections at the conclusion of a two-year probationary period with regular attendance.
 - ii. Not be eligible for election to any office in the MSS.
 - iii. Be able to present his or her organization's policies and opinions in the Assembly Meeting.
 - iv. Report on the actions of the MSS to the national medical student organization.
 - v. Cooperate in enhancing the MSS membership.
 - f. MSS Delegates and Alternate MSS Delegates selected by national medical student organizations must meet the following criteria:
 - i. Must be medical student members of the AMA in good standing.
 - ii. Should be chosen in a fair and equitable manner allowing open representation and medical student input.
 - iii. Must be certified in writing by the president, or appropriate staff person, of the organization they will be representing.
 - iv. Must represent the interests of their organization's medical student constituency.
4. Other Groups.
- a. The Association of American Medical Colleges – Organization of Student Representatives and the American Association of Colleges of Osteopathic Medicine – Council of Osteopathic Student Government Presidents are each entitled to one MSS Delegate and one Alternate MSS Delegate selected by the medical student members of the organization.
 - b. MSS Delegates and Alternate MSS Delegates selected from these organizations must meet the following criteria:
 - i. Must be medical student members of the AMA in good standing.
 - ii. Should be chosen in a fair and equitable manner allowing open representation and medical student input.
 - iii. Must be certified in writing by the president, or appropriate staff person, of the organization they will be representing.
 - iv. Must represent the interests of their organization's medical student constituency.
5. Official Observers.

- a. National student organizations may apply to the MSS Governing Council for official observer status in the MSS Assembly. Applicants and official observers must demonstrate compliance with guidelines for official observers adopted by the MSS Assembly, and the Governing Council shall make a recommendation to the MSS Assembly concerning the application. The MSS Assembly will make the final determination on the conferring or continuation of official observer status.
- b. Organizations with official observer status are invited to send one representative to observe the actions of the Assembly at all meetings of the MSS Assembly. Official observers have the right to speak and debate on the floor of the Assembly upon invitation from the Speaker. Official observers do not have the right to introduce business, introduce an amendment, make a motion, or vote.

D. Purposes of the Meeting. The purposes of the meeting shall be:

1. To hear such reports as may be appropriate.
2. To elect, at the Assembly meeting prior to the Interim Meeting of the AMA, the Chair-elect of the Governing Council of the MSS, and the Medical Student Trustee. To elect at the Assembly meeting prior to the Annual Meeting of the AMA, the remaining members of the Governing Council, with the exception of the Immediate Past Chair.
3. To adopt procedures for election of Medical Student Regional Delegates and Alternate Regional Delegates, consistent with AMA Bylaw 2.1.3.
4. To elect Medical Student Regional Delegates and Alternate Regional Delegates at the Assembly meeting prior to the Interim Meeting of the AMA.
5. To adopt resolutions for MSS policy and for submission to the House of Delegates of the AMA.
6. To conduct such other business as may properly come before the meeting.

E. Credentialing. The name of the duly selected MSS Delegate and Alternate MSS Delegate from each educational program, national medical specialty society, federal service, professional interest medical association, national medical student organization, and other group, and the representative from each official observer organization, should be received by the ~~Director of Medical Student Services~~ Medical Student Section staff of the AMA no later than ~~350 days (five weeks)~~ prior to the Assembly Meeting in writing, as outlined in these Internal Operating Procedures. On the day of the opening of the Assembly Meeting, credentialing will take place, where voting members must officially identify themselves to the Credentials Committee as having been duly selected by the AMA medical student members of their respective organizations. Identification will be required to receive a voting badge. Graduating or recently graduated senior medical students who have been credentialed as RFS Delegates or Alternate RFS Delegates in the representative assembly of the AMA Resident and Fellow Section shall not be allowed to serve as MSS Delegates or Alternate MSS Delegates in the MSS Assembly.

F. Participation.

1. Only duly selected MSS Delegates to the Assembly Meeting shall have the right to vote, but the meeting floor shall be open to all medical students ~~and~~ AMA members.
2. The Immediate Past Chair of the MSS Governing Council shall have the same speaking privileges, excluding the privilege to make a motion, in the MSS Assembly as any other member of the Governing Council if he or she is no longer a medical student.
3. ~~If the Presiding Officer is a representative to the MSS Assembly meeting, he or she shall be entitled to vote only when the vote is by ballot or to break a tie. If the Presiding Officer is not a representative to the MSS Assembly Meeting, he or she shall be entitled to vote only to~~

~~break a tie.~~ The Presiding Officer shall be entitled to vote only to break a tie.

G. Procedure.

1. Agenda. At least ~~24~~30 days prior to the Assembly Meetings, the agenda shall be sent to MSS Delegates and Alternate MSS Delegates. The order of business will be set by the Speakers prior to the meeting. ~~The Assembly at any time may change the order of business by a majority vote.~~ may only change the order of business in accordance with the procedures set in the AMA Bylaws, MSS IOPs, and the parliamentary authority of the AMA outlined in B-11.1.
2. Rules of Order. The Assembly meeting shall be conducted pursuant to the established rules of procedure submitted by the Speakers and adopted by the Assembly. The parliamentary authority used by the AMA House of Delegates shall govern the Assembly Meeting of the MSS in all matters not outlined in the adopted rules of procedure mentioned above.
3. Quorum. Twenty-five percent of the MSS Delegates shall constitute a quorum, provided that at least ten percent of the MSS Delegates from each of the geographic regions are present. The regions are defined in MSS Internal Operating Procedures VIII.A.1. For the purposes of defining a quorum, the MSS Delegate of each national medical specialty society, federal service, professional interest medical association, national medical student organization, and other group is considered part of the region representing the state in which his or her organization's headquarters are located.

H. Resolutions.

1. Any medical school section, MSS region, state student section, or individual medical student member may submit resolutions.
2. All resolutions submitted by medical students must be submitted electronically to the AMA Department of Medical Student Services 50 days prior to the start of each Annual and Interim Meeting to be included in the MSS agenda. ~~They will be sent to all duly selected and certified MSS Delegates and Alternate MSS Delegates prior to the Assembly Meeting and are debatable on the floor of the MSS Assembly.~~
 - a. Virtual Reference Committee. All reports and resolutions that meet submission criteria will be made available on the Virtual Reference Committee. Any AMA MSS member can comment on MSS business. Comments can be made on behalf of an individual, a medical student section at a medical school, a state medical student section, an organization represented in the Assembly, and/or an AMA MSS Region, provided sufficient authority exists for such commentary. All comments will be made available to the Reference Committee(s). The resolutions will be sent to all duly selected and certified MSS Delegates and Alternate MSS Delegates prior to the Assembly Meeting via the meeting Agenda and are debatable on the floor of the MSS Assembly.
3. Late Resolutions. Resolutions that are submitted after the deadline but before the beginning of the meeting shall require a two-thirds vote of the Assembly to be debatable on the floor. The Rules Committee shall make recommendations to the Assembly on whether they should be considered as business based on timeliness of the issue and temporality relative to the resolution submission deadline. Late resolutions approved for consideration shall be referred to the Reference Committee, and handled in the same manner as those resolutions introduced before the deadline.
 - a. Late Resolutions amending the MSS Internal Operating Procedures or proposing to amend AMA Bylaws ~~submitted less than 40 days prior to the start of each Annual and Interim meeting~~ shall not be considered.

4. Emergency Resolutions. Resolutions that are submitted after the beginning of the meeting shall require a three-fourths vote of the Assembly to be debatable on the floor. ~~The Rules Committee shall make recommendations to the Assembly on whether they should be considered for business.~~ The motion to hear an emergency resolution is not debatable and only a statement on the timeliness of the resolution may be made. Emergency resolutions approved for consideration shall be debated on the floor of the Assembly without referral to the Reference Committee.
5. Resolutions approved for consideration as business shall require a simple majority vote of the Assembly for adoption, except those amending the MSS Internal Operating Procedures or proposing to amend the AMA Bylaws, which, ~~pursuant to MSS Internal Operating Procedure XII,~~ require approval by two-thirds of the members of the MSS Assembly present and voting.
6. Extraction of a resolution recommended for reaffirmation by the Reference Committee shall require a one-third vote of delegates present and voting.
7. Resolutions introduced by the Governing Council into the AMA-MSS Handbook shall be in the name of the AMA Delegate. Such resolutions may only be submitted when there is unanimous approval by all five voting members of the Governing Council. They shall be considered by the MSS Assembly as a first priority of business, ~~and if not adopted or amended, shall be withdrawn from the AMA House of Delegates.~~
8. Resolutions shall be submitted to the AMA House of Delegates in the name of the MSS when they have received the prior approval of the MSS Assembly.

I. Convention Committees. The Convention Committees shall be appointed by the Governing Council unless otherwise stated in these procedures. These committees are to expedite the conduct of business at each meeting of the MSS Assembly. For each meeting, the Governing Council will appoint the following committees and any others that would facilitate the business of the Assembly.

1. Credentials Committee. An eight member Credentials Committee, composed of one member per region ~~as defined in MSS Internal Operating Procedures VII.A.1.,~~ unless there are no candidates from a region, and one Chair, shall be appointed by the Governing Council. The Committee shall be responsible for consideration of all matters relating to the registration and certification of MSS Delegates including credentialing MSS Delegates for Assembly Meetings, verifying a quorum is present, and distributing ballots for elections. Disputes involving the credentialing of voting delegates will be investigated by the Credential Committee.
2. Rules Committee. A Rules Committee shall be composed of four At-Large Members. The Rules Committee shall review late ~~and emergency~~ resolutions and make recommendations to the MSS Assembly on whether to consider them as business of the Assembly. The Rules Committee shall also collect and tabulate ballots for MSS elections, and count hand votes during the Assembly Meeting as requested by the Speakers. The Rules committee is also responsible for ensuring election rules are followed in coordination with the MSS Speaker and Vice-Speaker.
3. Reference Committee. ~~The Each~~ Reference Committee shall be composed of five voting members ~~and one alternate member~~ unless, in the judgment of the Governing Council, circumstances warrant an adjustment in the number of members on the Reference Committee. The committee shall conduct an open hearing on items of business referred to it (resolutions and reports) via the MSS Virtual Reference Committee, and make recommendations to the Assembly for disposition of its items of business through the preparation of Reference Committee report for consideration by the MSS Assembly.

4. Parliamentary Procedures Committee. The Parliamentary Procedures Committee members shall demonstrate a thorough understanding of ~~The Standard Code of Parliamentary Procedure~~ the parliamentary authority set forth by these Internal Operating Procedures in order to assist students with parliamentary procedures throughout the Assembly meeting.
5. AMA House of Delegates Coordinating Committee. House Coordinating Committee members shall be appointed to coordinate student testimony that will be presented at the AMA House of Delegates Reference Committee hearings. The Coordinators shall work with the AMA Delegate and Alternate AMA Delegate in the preparation and presentation of testimony for resolutions being transmitted by the MSS and additional items of relevance to the MSS. "; and be it further

RESOLVED, That our AMA-MSS amend IOP XI by insertion and deletion as follows:

"XI. Appointments

A. Governing Council Responsibilities. It will be the responsibility of the Governing Council to make appointments of the medical student members of AMA Councils for confirmation by the AMA Board of Trustees and to other bodies of the AMA when requested. It is also the responsibility of the Governing Council to make recommendations for student representation to bodies such as the National Board of Medical Examiners, National Resident Matching Program, and others after the Governing Council has solicited applications from interested medical students.

B. Eligibility. Eligibility for Council and Liaison positions shall be pursuant to MSS Internal Operating Procedures VI.B.

C. Medical Student Representation on AMA Councils.

1. A medical student member of the AMA appointed by the MSS Governing Council with the concurrence of the Board of Trustees shall serve on each of the following AMA Councils:
 - a. Council on Constitution and Bylaws.
 - b. Council on Medical Education.
 - c. Council on Medical Service.
 - d. Council on Long Range Planning and Development.
 - e. Council on Scientific Affairs and Public Health.
2. A student is recommended by the MSS Governing Council to the AMA President-elect for consideration for appointment to the student seat on the Council on Ethical and Judicial Affairs.
3. A student is recommended by the MSS Governing Council to the AMA Board of Trustees for consideration for appointment to the student seat on the Council on Legislation.
4. A student is recommended by the MSS Governing Council to the AMA Board of Trustees for consideration for appointment to the student seat on the Liaison Committee on Medical Education (an AMA/Association of American Medical Colleges joint committee).
5. In any discussion or selection of candidates for appointment to Council or Liaison positions, all Governing Council members who are candidates for the position under discussion or have significant conflicts of interest shall recuse themselves and be absent from this discussion.
 - a. The MSS Chair, or their designee, shall be responsible for ensuring a fair and thorough evaluation process by the Governing Council.
6. All applicants for Council and Liaison positions shall be informed of the Governing

Council's decision to appoint or not appoint them ~~at least three months prior to the Annual Meeting, as soon as the appointments are confirmed by the AMA Board of Trustees, President, or President Elect.~~

7. Terms. Students appointed to Councils shall serve for a one-year term with the exception of the student appointed to the Council on Ethical and Judicial Affairs, who will serve for a two-year term. If the medical student member of a Council ceases to be enrolled in an approved program, his or her service on the Council shall thereupon terminate, and the position shall be declared vacant.
8. Limitation on Total Years of Service. See MSS Internal Operating Procedures IV.G. “; and be it further

RESOLVED, That our AMA-MSS amend IOP XII by insertion and deletion as follows:

“XII. Miscellaneous

~~**A. Parliamentary Authority.** The prevailing parliamentary code of our AMA governs this organization in all parliamentary situations that are not provided for in the law or in the AMA-Bylaws or these Internal Operating Procedures.~~

~~**BA. Financial Responsibility.** The funding of the MSS Governing Council is appropriated by the AMA. A listing of all meetings attended by each member of the Governing Council and members of AMA Councils, Committees, and Panels, along with an account of pertinent actions taken, will be made available to MSS members semi-annually upon request. “; and be it further~~

RESOLVED, That our AMA-MSS amend IOP XIII by insertion and deletion as follows:

“XIII. Dispute Resolution.

~~**A.** All disputes of these Internal Operating Procedures shall be resolved by the AMA Board of Trustees (BOT) with provision for input from other parties as deemed necessary by the BOT, except in the following instances as defined elsewhere in these Internal Operating Procedures:~~

~~**A-1.** All disputes involving Regional Delegate or Alternate Delegate elections shall be resolved by the MSS Governing Council.~~

~~**B- 2.** All disputes involving Campaign Rules (MSS IOPs V.D.) as related to the MSS shall be resolved by the MSS Speaker and Vice Speaker. “; and be it further~~

RESOLVED, That our AMA-MSS amend IOP XIV by insertion and deletion as follows:

“XIV. Amendments to the Internal Operating Procedures

~~**A. MSS Requirements.** These Internal Operating Procedures may be amended by the approval of two-thirds of the members of the MSS Assembly present and voting. Amendments to these Internal Operating Procedures must be submitted 50 days in advance of the Assembly so that the Governing Council and MSS Delegates can study the implications of the proposed changes.~~

~~**B. A. Other Requirements.** Per AMA Bylaw 7.0.7, all rules, regulations, and procedures adopted by the MSS are subject to the approval of the Board of Trustees. Amendments to the Internal Operating Procedures may also be contingent upon corresponding changes to the AMA Bylaws, which require approval of two-thirds of the members of the AMA House of Delegates. “~~

APPENDIX A: IOPs with All Changes

American Medical Association Medical Student Section

Internal Operating Procedures

I. Name

The name of this organization shall be the Medical Student Section (MSS) of the American Medical Association (AMA). This is a special section for medical student members of the AMA as set forth in AMA Bylaw 7.3.

II. Purpose and Principles

The purpose of the MSS shall be to provide medical student participation in the activities of the AMA through adherence to the following principles:

- A.** Have meaningful input into the decision and policy-making process of the AMA.
- B.** Improve medical education and further professional excellence.
- C.** Involve medical students in addressing and solving the problems of health care and health care delivery and provide a forum for the discussion and dissemination of information.
- D.** Develop medical leadership.
- E.** Initiate and effect necessary change.
- F.** Promote high personal and professional ethics, and a humanistic approach to the delivery of quality patient care.
- G.** Promote membership and activity within organized medicine on the local, state, and national levels.
- H.** Work cooperatively with other student groups and AMA Sections to meet these objectives.

III. Membership

Membership shall be limited to medical student members of the AMA. Eligibility for student membership is outlined in AMA Bylaw 1.1.1.

IV. Officers

- A. Designations.** The officers of the MSS shall be the eight Governing Council

members: Chair, Vice Chair, AMA Delegate, Alternate AMA Delegate, At-Large Officer, Chair-elect/Immediate Past Chair, Speaker, and Vice Speaker. The Chair-elect/Immediate Past Chair shall be a non-voting member of the Governing Council. The officers of the Assembly for the purpose of business meetings will be the Speaker and Vice Speaker.

B. Authority. The Governing Council shall direct the programs and activities of the MSS. During the interval between meetings of the MSS Assembly, the Governing Council shall act on behalf of the MSS in formulating decisions related to the development, administration, and implementation of student activities, programs, goals, and objectives. The MSS shall be notified at each National Meeting of actions taken by the Governing Council on its behalf.

C. Qualifications. All members of the Governing Council must be medical student members of the AMA. Any medical student member of the AMA is eligible for a position on the MSS Governing Council, except as prohibited by these IOPs or by the AMA Bylaws.

D. Duties and Privileges. The Governing Council shall direct the programs and activities of the MSS, subject to the approval of such programs and activities by the Board of Trustees or House of Delegates of the AMA.

1. Chair. The Chair shall:

- a. Preside at all meetings of the Governing Council, and otherwise represent the MSS when appropriate.
- b. Preside at Assembly meetings if both the Speaker and Vice Speaker positions are vacant, until such time that successors to the Speaker or Vice Speaker may be elected.
- c. Be the primary spokesperson for the MSS both inside the AMA and to outside organizations

2. Vice Chair. The Vice Chair shall:

- a. Perform the duties of the Chair in the absence of the Chair or at the request of the Chair.
- b. Assist the Chair in the performance of his or her duties.
- c. Have the primary responsibility of coordinating the internal operations of the MSS including but not limited to the MSS standing and ad-hoc committees.

3. AMA Delegate and Alternate AMA Delegate shall:

- a. Represent the MSS in the AMA House of Delegates including credentialing of region delegates and alternate delegates.

- b. Serve as chair and vice chair, respectively, of the MSS Caucus.
 - c. Be responsible for forwarding resolutions from the MSS in the HOD and providing a summary of pertinent actions for the MSS on resolutions sent to the HOD.
 - d. Administer the MSS resolution review process.
 4. At-Large Officer shall:
 - a. Perform such functions as determined by the Governing Council, and assist the other officers in the performance of their duties.
 - b. Coordinate the activities of the MSS Regions
 5. Speaker and Vice Speaker. The Speaker and Vice Speaker shall:
 - a. Preside over meetings of the MSS Assembly in an impartial manner, organizing and conducting them in accordance with AMA Bylaws, MSS Internal Operating Procedures, and the AMA's chosen authority on parliamentary procedure. The Vice Speaker shall officiate for the Speaker in the Speaker's absence or at the request of the Speaker.
 - b. Provide for oversight and enforcement of the Campaign Rules, including responsibility for investigation of alleged infractions and reporting of substantiated infractions to the Assembly prior to balloting.
 - c. Organize an orientation at each Assembly Meeting for first time attendees to the MSS General Assembly.
 - d. Work with other members of the Governing Council in instructing the Convention Committees regarding their duties prior to each Assembly Meeting.
 - e. Refer resolutions and reports submitted for consideration at MSS Assembly meetings to reference committees.
 - f. Prepare a document summarizing parliamentary procedure used in Assembly meetings to be published in the MSS agenda book that is made available to each Assembly representative prior to Assembly meetings.
 - g. Review the MSS Digest of Actions for consistency with Assembly action prior to its annual posting to the AMA website.
 6. Chair-elect. The Chair-elect shall be a non-voting, funded member of the Governing Council. The Chair-elect shall assist the other officers in the

discharge of their duties.

7. Immediate Past Chair. The Immediate Past Chair shall be a non-voting, unfunded member of the Governing Council.

E. Governing Council Terms.

1. The Chair-elect/Chair/Immediate Past Chair of the Governing Council shall serve a two-year term. His or her term as Chair-elect will begin at the conclusion of the Interim Meeting at which he or she is elected. He or she will take office as Chair at the conclusion of the following Annual Meeting, and one year later will become Immediate Past Chair. He or she will serve as Immediate Past Chair until the conclusion of the following Interim Meeting.
2. The other Governing Council members shall serve one-year terms, beginning at the conclusion of the Annual Meeting at which they are elected and ending at the conclusion of the next Annual Meeting of the AMA House of Delegates.
3. Maximum tenure for members of the MSS Governing Council will be two years in voting positions.

F. Vacancies.

1. Governing Council. Any vacancy occurring on the MSS Governing Council shall be filled at the next Assembly Meeting of the MSS. The new member shall be elected for the remainder of the unexpired term in the same manner as the original election, as outlined in MSS Internal Operating Procedures V.
 1. Temporary Appointment. If a vacancy occurs on the Governing Council more than thirty (30) days prior to the next Assembly Meeting of the MSS, the Governing Council may appoint a medical student member to fill a vacancy until the next Assembly Meeting of the MSS when an election shall be held pursuant to the above rules.
2. Speaker and Vice Speaker. If the position of Speaker becomes vacant, the Vice Speaker shall succeed to the position of Speaker and serve the remainder of the unexpired term as Speaker. If the Vice Speaker assumes the role of a Speaker for the remainder of the unexpired term, the Representatives to the MSS Assembly Meeting shall elect a Vice Speaker to fill the unexpired term at the next Assembly Meeting, as outlined in Section V of the MSS Internal Operating Procedures. If both Speaker and Vice Speaker positions are vacant, the Chair of the Governing Council shall preside, as specified in IOP Section IV, D 1.

G. Limitation on Total Years of Service. Students deemed qualified by the other

provisions of the AMA Bylaws and these Internal Operating Procedures for election to the positions of:

- MSS Governing Council, or
- The AMA Board of Trustees, or
- Appointment through the MSS to a position on an AMA Council, or
- A committee outside of the AMA that is national in scope and appointed by the Governing Council, the AMA President, the AMA President-elect or the AMA Board of Trustees (such as National Board of Medical Examiners, National Resident Matching Program, American Medical Association Political Action Committee, Liaison Committee on Medical Education, etc.)

shall be only so deemed if they have served three or fewer years in one or a combination of any of the aforementioned positions. The intent of this Section is to limit combined service in all of these positions to four years total. A person may not serve in the same position for more than two years, even if he or she has not reached his or her four year total limit. This Section shall not encompass positions that are not national in scope (i.e. Regional or State Delegates, Regional or State Chairs, etc.) nor shall it encompass appointments to the internal MSS Committees or Task Forces. The exceptions to this Section are as follows:

1. Unless otherwise provided in the AMA Bylaws.
2. The position of Immediate Past Chair of the Governing Council shall not be denied to a student on the basis of having already served four years pursuant to the foregoing provision, but the service in the position of Chair-elect/Immediate Past Chair shall otherwise count as a year of service.

V. Medical Student Trustee

A. Duties and Privileges. A medical student member of AMA shall be elected annually by the MSS Assembly to serve as a member of the AMA Board of Trustees. The student member of the Board of Trustees shall report on the Board's activities to the Assembly before the Annual Meeting. This report will communicate Board Actions related to the concerns of the MSS and will provide the MSS with directives on behalf of the Board.

B. Term. The MSS Assembly shall elect the Medical Student Trustee at the Interim Meeting for a one-year term beginning at the close of the next AMA House of Delegates Annual Meeting and concluding at the close of the second AMA House of Delegates Annual Meeting following the meeting at which the member was elected.

VI. Elections

- A. Time of Election.** The Chair-elect of the Governing Council and Medical Student Trustee shall be elected by the MSS Assembly at the Interim Meeting. The remaining Governing Council members, with the exception of the Immediate Past Chair, shall be elected by the MSS Assembly at the Annual Meeting of the MSS. The Governing Council shall set the day and hour of such elections and shall communicate the day and hour to the medical student members of the AMA prior to each Interim Meeting and Annual Meeting.
- B. Eligibility.** All members of the MSS are eligible to be elected to any office, except:
1. MSS members who serve or will serve in an shall an AMA Council or AMA Liaison position may not also serve or run to serve in a Governing Council position or the Medical Student Trustee position at the same time for more than two months. The only exception shall be that a MSS member may hold an AMA Council or AMA Liaison position and the position of Chair-elect or Immediate Past Chair simultaneously.
- C. Nominations.** Nominations for Governing Council positions shall be received in advance of the Annual Meeting (in advance of the Interim Meeting for the Chair-elect and Medical Student Trustee), pursuant to the rules of the MSS. Further nominations may be made from the floor of the Assembly Meeting at a time determined by the Governing Council.
- D. Speeches.** Candidates are allowed to address the Assembly for a period of time determined by the Speakers up to a maximum of three minutes during a general Assembly session, as scheduled by the Speakers. In addition, the Chair of the Governing Council, or his or her designee, shall ask each candidate a number of questions on issues of relevance during a general Assembly session, as scheduled by the Speakers.
- E. Campaign Rules.**
1. **Candidacy.** All MSS members shall be considered potential candidates for all elected offices and shall be bound by all Campaign Rules during the election cycle for each office, where the election cycle for an office is defined as the time between elections for that office.
 2. **Campaign Period.**
 - a. Campaigns shall be run only for positions that are electable at the present meeting.
 - b. Between meetings, campaigns shall be run only for positions that are electable at the upcoming meeting.
 - c. The official campaign period shall be defined as starting the first

day applications are made available for MSS members to submit their candidacy

- d. All activities related to announcement of candidacy, endorsement, or campaigning, including but not limited to distribution of materials, communications, and speaking opportunities shall be limited to the campaign period defined above.

3. Speaker's Ruling

- a. A Speaker's Ruling for the each national meeting and election will be made available to all potential candidates at the start of the campaign period with a document of rulings so that all candidates have equal access to all rules relating to their campaigns. Once released, the MSS Speakers' reserve the right to issue addendums or announcements during the campaign period as needed.

4. Candidate Disclosure Form.

- a. The day before the election is scheduled to occur, all candidates nominated, either in advance of the meeting or from the floor at the meeting, shall submit a completed Candidate Disclosure Form to the Speaker, the Vice Speaker, or a member of the Rules Committee no later than the time of day designated by the Speaker. No candidate shall be elected if he or she has not completed and submitted a Candidate Disclosure Form.
- b. The Candidate Disclosure Form shall be prepared by the Speaker and Vice Speaker and shall consist of three parts:
 - i. A portion, completed by the candidate, for disclosure of campaign leadership and campaign finances.
 - ii. A portion, completed by the candidate, affirming that the candidate has read the IOP sections relevant to campaigning and the Speakers' Rulings for that election cycle and agrees to abide by the rules and recommendations contained within those documents.
 - iii. A portion, completed by the Speaker or Vice Speaker, for disclosure of any prior, substantiated infraction(s) of MSS IOPs by the individual declared as a candidate.

5. Candidates may distribute only the following campaign materials:

- a. Buttons, stickers, and pins less than 2.5 inches in greatest dimension.

- b. Standard-size business cards.
 - c. Curricula vitae and personal statements.
 - i. Curricula vitae and personal statements of candidates nominated, pursuant to the rules of the MSS, in advance of the national meeting at which the election will be held shall be included in the online version of the MSS Meeting Handbook.
 - ii. At the Assembly Meeting, distribution of curricula vitae and personal statements shall be limited to the area and medium/media designated by the Speaker and announced at least 30 days prior to the meeting at which the election will be held.
 - iii. While there will be no limit on the length of curricula vitae, personal statements will be limited to one page (front and back).
6. The total expenditure per candidate per campaign shall not exceed \$1,000, including all monetary donations and in-kind donations of goods, but not including the candidate's travel to and lodging at the meeting at which the election is held.
7. Campaign Communications.
- a. Advance non-electronic mailings by candidates or other organizations on behalf of a candidate are not permissible.
 - b. Candidates should be prudent and courteous regarding the number and content of electronic messages, including but not limited to email, social media, phone, text message, and group chats, sent prior to the election.
 - c. No mode of MSS or AMA sponsored communication, including but not limited to listservs, phone or email lists, or other mass communication method used for AMA or MSS communication shall be used for announcements of candidacy, endorsement, or campaigning.
 - d. Candidates using campaign-specific social media accounts can only invite MSS members to follow said accounts.
8. Campaigning at MSS Regional, state, or school section meetings prior to the meeting at which the election occurs including attending social events, is prohibited. The candidate's own MSS Region, state, or school section meetings are an exception to this rule. Campaigning includes, but is not limited to, discussing candidacy or displaying or distributing

campaign paraphernalia.

9. Campaign Involvement.

- a. Only MSS members may be involved in a candidate's campaign. MSS members should not share their opinion in favor of or in opposition to any candidate while acting under any official leadership role within or outside of the organization.
 - i. Exception: Candidates may wear their own campaign paraphernalia at all times during the Assembly Meeting at which their election is held.
- b. The campaign involvement of AMA staff members, members of the MSS Governing Council, and members of the MSS Rules Committee shall be limited to candidate inquiries regarding election-related matters and AMA-related information so long as that information is made available to all MSS members who request it.
- c. The following public endorsements are permitted:
 - i. One (1) optional letter of endorsement by the Dean or Dean's representative from the medical school that the candidate is enrolled in; and one (1) optional letter of endorsement by staff of the state society from the state where the candidate attends medical school are permitted.
 1. These optional letters of endorsement may be included in the Election Manual and may be displayed on social media.
 2. During a national meeting, these letters may only be publicly disseminated via the Election Manual and may only be publicly displayed at the candidate forum.
 - ii. One (1) optional letter of endorsement and a verbal endorsement by each candidate's MSS Region where their school resides is permitted by vote within the campaign period.
 1. The endorsing Region must:
 - a. Follow the Region's bylaws regarding issuance of public endorsement;
 - i. If a Region does not have bylaws specifying quorum or rules dictating

11. At the national meeting at which the election is taking place, a group that invites any candidate for a particular office to speak must invite and make a reasonable effort to accommodate all candidates for that office. Candidates may choose at their discretion to attend or not or may send a representative to speak for them, but any candidate's availability or lack thereof shall not impose a restriction on the attendance of other candidates.
12. Receptions and/or hospitality shall not be used for promotion of candidates.
13. Enforcement.
 - a. Alleged infractions, including but not necessarily limited to violations of the Campaign Rules, should be reported in writing to the MSS Speaker or Vice Speaker, or to any member of the MSS Rules Committee.
 - b. The Speaker and Vice Speaker shall be the investigators of any alleged infraction in conjunction with the Rules Committee. No person who is a candidate in the same election as the candidate being investigated for alleged infractions may participate in any part of the investigation of those alleged infractions. The candidate is required to participate in the investigation.
 - i. In the event where both the Speaker and Vice Speaker are candidates for the election being investigated, the MSS Chair will designate a member of the Rules Committee as investigator to examine the alleged infraction.
 - c. Following the investigation, the investigator shall inform the alleged violator of the infraction in writing, including the results of the investigation of the alleged infraction. The alleged violator shall be offered an opportunity to rebut the alleged infraction. Following rebuttal, the investigator shall determine whether the alleged infraction is substantiated and shall report his or her finding in writing to the alleged violator.
 - d. Following the investigation and the alleged violator's opportunity to rebut the alleged infraction and prior to balloting, the investigator shall report substantiated infractions to the Assembly but shall not make any recommendation to the Assembly.
 - e. Enforcement of a campaign infraction shall follow a systematic approach. Each candidate, upon each substantiated infraction of the Campaign Rules, shall be given an official warning letter from the Speaker. Exceeding three (3) substantiated infractions during a campaign shall render a candidate ineligible for election during that campaign period.

F. Voter Eligibility. Credentialed MSS members acting as MSS Delegates for the meeting will be eligible to vote.

G. Method of Election.

1. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.
2. Voting Periods. There shall be one voting period at the Interim Meeting for the selection of the Chair-elect and Medical Student Trustee. There shall be one voting period at the Annual Meeting for the selection of the Vice Chair, AMA Delegate, At-Large Officer, and Speaker. An additional balloting period will be held for the elections of Alternate AMA Delegate and Vice Speaker.
3. First Ballot. At the Interim Meeting, one ballot shall be used by the credentialed MSS Delegate to cast one vote for the Chair-elect and Medical Student Trustee. At the Annual Meeting, individual ballots for each position shall be used by the credentialed MSS Delegate to cast one vote for each of the four positions: the Vice Chair, AMA Delegate, At-Large Officer, and Speaker. No ballot shall be counted if there is more than one vote for a position. All Governing Council positions will be determined by majority vote, that is, the candidate who has received the largest number of votes shall be elected if that nominee has received a majority of the legal votes cast.
 - a. Election of Alternate AMA Delegate. After the election of the AMA Delegate, all unsuccessful candidates who were nominated for the office of AMA Delegate may be added to the existing Alternate AMA Delegate ballot by nomination from the floor of the Assembly. Each MSS Delegate to the Assembly Meeting who is present at the meeting may cast a written ballot for the election of the Alternate AMA Delegate from the previously declared candidates and among those so nominated. Election to the office of Alternate AMA Delegate requires a majority of the legal votes cast.
 - b. Election of Vice Speaker. After the election of the Speaker, all unsuccessful candidates who were nominated for the office of Speaker may be added to the existing Vice Speaker ballot by nomination from the floor of the Assembly. Each MSS Delegate to the Assembly Meeting who is present at the meeting may cast a written ballot for the election of the Vice Speaker from the previously declared candidates and among those so nominated. Election to the office of Vice Speaker requires a majority of the legal votes cast.
4. Runoff Election. If no candidate receives a majority of the legal votes cast or there is a tie, a runoff election will be held between the two (or more if necessary because of a tie) candidates receiving the highest

number of legal votes cast.

5. Processing. No ballots will be cast after the expiration of the voting period. The ballot boxes will be collected by members of the Rules Committee. The Rules Committee and the ballot boxes will be sequestered in a private location. At this time, the Chair of the Rules Committee will open the ballot boxes and the Rules Committee will then count the ballots and tabulate the results. The candidate who has received the largest number of votes shall be elected if that nominee has received a majority of the legal votes cast. Upon completion of the tabulation, the Chair of the Rules Committee will validate the election results by determining that each ballot is official, that the number of ballots cast is equal to or less than the number distributed and will then certify the results in writing. He or she will then immediately forward these results to the Assembly's Presiding Officer. Upon receipt of the Rules Committee's election results and verification, the Presiding Officer will announce the results to the Assembly.
 - a. First Ballot. The credentialed MSS Delegate will receive one initialed ballot from a designated member of the Credentials Committee at the credentials table during the set voting period.
 - b. Runoff Election. If no candidate receives a majority of the legal votes cast or there is a tie, additional ballot(s) will be distributed by the Credentials Committee at the request of the Assembly's Presiding Officer. The candidate who receives a majority of the legal votes cast in the runoff election will be declared the winner.
6. Appeals. Appeals of the election process and results must be made in writing to the Assembly's Presiding Officer no later than one hour after the official announcement of the final results.
 - a. Any appeal of the process of ballot(s) distribution will be considered by the Rules Committee. Consideration of such appeals and merits of said appeals will be determined in whatever manner the committee deems necessary. The results of the committee's recommendations must be forwarded in writing by the Committee Chair to the Assembly's Presiding Officer.
 - b. Any appeal of the process of ballot processing, tabulation, and announcement of results shall be considered by the Credentials Committee. Consideration of such appeals and merits of said appeals will be determined in whatever manner the committee deems necessary. The results of the committee's recommendations must be forwarded in writing by the Committee Chair to the Assembly's Presiding Officer.
 - c. No person who is a candidate in the election being appealed may participate in any part of the appeals process.

- d. The Assembly's Presiding Officer and the Governing Council will consider the appeals report(s) from the Committee(s) dealing with the matter. Final decision on the election results will be the jurisdiction of the Governing Council.

VII. MSS Standing Committees and Task Forces

The MSS Standing Committees and Task Forces shall be appointed by the Governing Council and shall support the mission of the MSS as outlined in MSS Internal Operating Procedures.

VIII. Regions

A. Structure and Purpose of the MSS Regions.

1. There are seven Medical Student Regions defined for the purposes of electing Regional Delegates to the AMA House of Delegates from Medical Student Regions. The regions are:

Region 1: Washington, Oregon, California, Nevada, Utah, Colorado, Arizona, New Mexico, Montana, North Dakota, South Dakota, Idaho, Wyoming, Alaska, Hawaii.

Region 2: Minnesota, Wisconsin, Nebraska, Iowa, Missouri, Illinois.

Region 3: Kansas, Texas, Oklahoma, Arkansas, Louisiana, Mississippi.

Region 4: Florida, Georgia, Alabama, South Carolina, North Carolina, Tennessee, Puerto Rico.

Region 5: Michigan, Indiana, Ohio, Kentucky, West Virginia.

Region 6: Virginia, Maryland, District of Columbia, Delaware, New Jersey, Pennsylvania.

Region 7: Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New York

2. In addition to providing a structure for election of Regional Delegates, the MSS defines the roles of the regions as follows: to provide a home within the MSS, to serve as a communication unit for the MSS, to provide a means to foster collaboration between the sections and states, and to facilitate interaction and integration of newly developing sections with well-established sections.
3. Each region shall be governed by a Region Chair to be elected in accordance with the region's bylaws. The Region Chair will serve as the liaison for their respective region to the Governing Council. Other region officer positions may be elected in accordance with each regions' bylaws.

The role of the Region Chair is as follows:

- a. Encourage the organization of regional meetings as effective mechanisms of increasing communication among its members.
 - b. Encourage the development of local MSS sections in educational programs accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA) where local sections do not exist and the development of state MSS sections in states where they do not exist.
 - c. Involve highly organized MSS sections and state sections in providing organizational information and assistance to developing sections.
 - d. Encourage MSS sections to maintain communication and interaction between medical student members and physician members of state associations and component societies.
4. Each region shall have a Region Governing Council, which will be composed of the Region Chair and other elected or appointed officers of the region consistent with that region's regional bylaws and at the discretion of the Region Chair. The purpose of the Region Governing Council shall be to further fulfill the purpose of each region as defined in both the MSS Internal Operating Procedures and the region's bylaws.

B. Regional Delegates to the AMA House of Delegates.

1. Regional Delegates and Alternate Regional Delegates are part of the MSS Caucus led by the AMA Delegate and Alternate AMA Delegate. Credentialing of Regional Delegates and Regional Alternate Delegates is under the purview of the AMA Delegate and AMA Alternate Delegate.
2. MSS Responsibilities: The Regional Delegates and Alternate Regional Delegates will serve as mentors in the MSS and assist the AMA Delegate and Alternate AMA Delegate in reviewing MSS resolutions.
3. Apportionment and Seating. Each Medical Student Region is entitled to Regional Delegate and Alternate Regional Delegate representation based on the number of seats allocated to it by apportionment, as outlined in AMA Bylaw 2.3.2.
 - a. If a Regional Delegate cannot fulfill his or her duties, the Alternate Delegate shall assume the position of Regional Delegate and be seated with the state in which the Regional Delegate's educational program is located.
4. Qualifications. Each candidate for Regional Delegate or Alternate Regional Delegate must meet the following minimum qualifications:

- a. Any medical student member of the AMA is eligible for a Regional Delegate or Alternate Regional Delegate position, except as prohibited by AMA Bylaws, MSS IOPs, or Region bylaws.
 - b. All elected Regional Delegates and Alternate Regional Delegates must attend a medical school in the region in the region they are elected to represent.
5. Elections. The MSS will elect Regional Delegates and Alternate Regional Delegates to the AMA House of Delegates according to the following guidelines:
- a. Each Medical Student Region is responsible for electing its own Regional Delegates and Alternate Regional Delegates, based on the process identified in each region's bylaws.
 - b. Elections for the Regional Delegates and Alternate Regional Delegates to the AMA House of Delegates will be held at the Interim Meeting of the MSS. Each Region must submit the names of its newly-elected Regional Delegates and Alternate Regional Delegates to the MSS Governing Council before the close of the Interim Meeting.
 - c. Candidates will be required to submit a completed application including the written endorsement of the state association with which their educational program is located and curriculum vitae to the Medical Student Section staff by the published deadline each year to be kept on file by the Medical Student Section.
 - i. This provision may only be suspended if there are more Regional Delegate or Alternate Regional Delegate positions available than applicants who submitted on time or if there is a state in the region without an applicant.
 1. Applicants who do not submit their materials by the established application deadlines may be considered for available seats, but only after applicants who submitted their applications on time have been considered.
 2. Each region will determine whether or not to consider a candidate running from the floor from a state with no candidates who submitted on time simultaneously or after candidates from states with applicants who submitted on time.
 - ii. An RD/AD who is elected from the floor without having submitted the application materials by the deadline must submit such materials within 60 days of the election in order

to retain the position.

- d. Each state is entitled to a maximum of one Regional Delegate, unless there are fewer candidates than available positions or another state does not have a candidate that submitted their application on time. A state may have an unlimited number of Alternate Regional Delegates up to the maximum number of Regional Delegates.
- e. Medical Student Regional Delegates and Alternate Regional Delegates to the AMA House of Delegates are elected for one-year terms.
- f. All election disputes will be referred to the Governing Council.
- g. Each Region shall be free to institute more stringent requirements consistent with all other AMA and MSS rules.

C. Replacing Regional Delegates and Alternate Regional Delegates

1. Vacancies

- a. If vacancy in a Regional Delegate position is known, the Region Delegation Chair shall be responsible for nominating a replacement Regional Delegate from the Alternate Regional Delegates in the same region as the Regional Delegate that they are replacing in accordance with the region's bylaws at least 30 days prior to the meeting. All Regional Delegate replacements shall be approved at the discretion of the AMA Delegate and Alternate AMA Delegate. The replacement will serve the remainder of the Regional Delegate's Term per AMA Bylaw B-2.3.6.
- b. If vacancy in an Alternate Regional Delegate position is known, the Region Delegation Chair shall be responsible for nominating a replacement Alternate Regional Delegate from the same region as the Alternate Regional Delegate that they are replacing in accordance with the region's bylaws at least 30 days prior to the meeting. All Alternate Regional Delegate vacancies shall be approved at the discretion of the AMA Delegate and Alternate AMA Delegate. The replacement will serve the remainder of the Alternate Regional Delegate's Term per AMA Bylaw B-2.3.6.

2. Substitutes

- a. When a Regional Delegate or Alternate Regional Delegate is unable to attend a meeting of the House of Delegates, the AMA Delegate or AMA Alternate Delegate may appoint a substitute Regional Delegate or Alternate Regional Delegate, who on

presenting proper credentials shall be eligible to serve as such Regional Delegate or Alternate Regional Delegate in the House of Delegates at that meeting consistent with AMA Bylaw B-2.10.4

- i. All attempts will be made to work with the Region Delegation Chair of the region whose Regional Delegate or Alternate Regional Delegate is being replaced to find a student from the same region, but the position may be filled by a student from another region if no willing student from the same region can be found.

D. Creation of Regional Delegations to the House of Delegates. Through a mechanism of its own choosing, each Medical Student Region should appoint a member of its regional delegation to the House of Delegates, either a Regional Delegate or an Alternate Regional Delegate, to serve in the capacity of Regional Delegation Chair. The responsibilities of the Regional Delegation Chair should include:

1. Identify Regional Delegates and Alternate Regional Delegates who may be absent and suggest replacements in accordance with the MSS IOPs and the Region Bylaws.
2. Take attendance of the Regional Delegates and Alternate Regional Delegates from their region at House of Delegates meetings.
3. Mentor and orient inexperienced Regional Delegates.
4. Fulfill any other responsibilities assigned by the region.
5. Coordinate resolution authorship in the region for the MSS Assembly.

IX. MSS Caucus to the HOD

A. MSS Caucus Structure

1. The MSS Caucus is comprised of the following members: The AMA Delegate and Alternate AMA Delegate; the Regional Delegates and Alternate Regional Delegates; any MSS member serving as a Delegate or Alternate Delegate on a state delegation; and any MSS member serving as a Delegate or Alternate Delegate on a specialty society delegation.
2. The AMA Delegate and Alternate AMA Delegate shall be considered the Chair and Vice Chair of the caucus, respectively, and their responsibilities in those positions include, but are not limited to:
 - a. Overseeing debate, discussion, and voting that occurs within the caucus.
 - b. Assigning Regional Delegates or Alternate Regional Delegates to

serve on ad hoc caucus reference committees.

- c. Speaking on behalf of the MSS in reference committee hearings and the HOD or delegating the responsibility to speak on behalf of the MSS on certain resolutions and/or reports to other members of the caucus.
- d. Developing general MSS strategy for supporting or opposing resolutions and/or reports.
- e. Coordinating and negotiating with the leadership of other groups within the HOD.

B. Determining MSS Caucus Positions on AMA HOD Resolutions

- 1. For all MSS Caucus activities requiring a vote, all members of the caucus shall be given one vote.
- 2. A quorum of at least one half of potential voting members must participate for a vote to be valid.
- 3. In the AMA HOD, the MSS Caucus must take positions on resolutions that are consistent with the existing policy of the MSS as defined in the MSS Digest of Actions whenever relevant MSS policy exists.
- 4. In areas where relevant MSS policy exists, but the interpretation is uncertain, a majority vote of a quorum of delegates will determine the caucus's interpretation.
- 5. When a resolution is before the AMA HOD that is of significant importance to the MSS, but for which no MSS policy exists, any member of the MSS Caucus may move that the MSS take a position on the resolution. Such a movement requires a second by another caucus member and a 2/3rds majority vote to pass.
- 6. Positions set using the procedures described in section IX.B.5 are valid for the duration of that meeting only and do not apply to future Interim or Annual meetings.
- 7. The MSS Caucus may not take positions that are contrary to existing MSS policy.

C. Reporting of Caucus Actions. The AMA Delegate and Alternate AMA Delegate shall be responsible for authoring a report of actions taken, which shall be presented to the MSS Assembly at the next national meeting. This report will list the Resolve clauses of all AMA HOD resolutions for which the MSS took a position, including the position taken by the MSS Caucus, and will identify those resolutions for which the MSS Caucus took a position that was not grounded in existing internal policy.

X. MSS Assembly Meeting

A. Date and Location. There shall be an Assembly Meeting of medical student members of the AMA (MSS) held prior to each meeting of the AMA House of Delegates at a time and place fixed by the Executive Vice President of the AMA.

B. Call to the Meeting. Thirty days prior to the meeting, notice shall be sent to all medical students and medical student organizations detailing the time, place, credentialing process, resolution mechanisms, election procedures, and education programs for the meeting.

C. Representatives to the Assembly Meeting.

1. Educational Programs.

- a. **Central Campuses.** The AMA medical student members of each educational program as defined in AMA Bylaw 1.1.1 (a “central campus”) may select one MSS Delegate and one Alternate MSS Delegate. An educational program as defined in AMA Bylaw 1.1.1 that has a total medical student population (excluding students assigned to associated satellite campuses as defined in MSS Internal Operating Procedure X.C.1.b.) greater than 999, as determined by the AMA on January 1 of each calendar year, may select one additional MSS Delegate and one additional Alternate MSS Delegate.
- b. **Satellite Campuses.** The AMA medical student members of an educational program as defined in AMA Bylaw 1.1.1 that has more than one campus (a “satellite campus”) may select one MSS Delegate and one Alternate MSS Delegate from each campus. A satellite campus is defined as an administrative campus separate from the central campus where a minimum of 20 members of the student body are assigned for some portion of their instruction over a period of time not less than an academic year. MSS Delegates and Alternate MSS Delegates credentialing under the satellite campus provisions must, at the time of the meeting, reside at the campus they will represent.
 - i. A request to seat an MSS Delegate from a satellite campus for the first time must be submitted to the AMA Medical Student Section Staff at least 90 days in advance of the first Meeting at which an MSS Delegate will be seated. The request must confirm that the satellite campus meets the requirements for representation set forth in MSS Internal Operating Procedure X.C.b. and in AMA Bylaw 7.3.3.2.
- c. **Certification.** Educational program MSS Delegates and Alternate MSS Delegates shall be certified to the Governing Council of the MSS by either a student officer of the educational program or a

State Medical Student Section where it exists.

2. National Medical Specialty Societies, Federal Services, and Professional Interest Medical Associations.
 - a. Eligibility. The following criteria have been developed for national medical specialty societies, federal services, and professional interest medical associations to qualify for representation in the MSS Assembly. Pursuant to AMA Bylaw 7.3.3.3, a national medical specialty society, federal service, or professional interest medical association must:
 - i. Have voting representation in the AMA House of Delegates.
 - ii. Allow for medical student membership.
 - iii. Have established a mechanism that allows for the regular input of medical student views into the issues before the organization.
 - b. A national medical specialty society, federal service, or professional interest medical association that satisfies the criteria in MSS IOP X.C.2.a may select one MSS Delegate and one Alternate MSS Delegate. MSS Delegates and Alternate MSS Delegates selected from national medical specialty societies, federal services, or professional interest medical associations must meet the following requirements:
 - i. Must be medical student members of the AMA in good standing.
 - ii. Should be chosen in a fair and equitable manner allowing open representation and medical student input.
 - iii. Must be certified in writing by the president, or appropriate staff person, of the organization they will be representing.
 - iv. Must represent the interests of their organization's medical student constituency.
 - c. Application Process. An application will be provided to interested national medical specialty societies, federal services, and professional interest medical associations. The organization should submit the application form, and any other documents demonstrating compliance with these criteria, to the MSS Governing Council at least ninety days prior to the first Meeting at which they wish to seat an MSS Delegate. Upon approval by the Governing Council, the organization will be granted a seat in the

MSS Assembly with voting privileges on all matters except elections. The newly seated organization will be placed on probationary status for a period of two years, during which time consistent attendance at the four national Assembly Meetings is expected. At the conclusion of this probation period, the MSS Delegate selected by the organization will attain full voting privileges, including elections, and will be eligible to run for office. The Governing Council will notify the organization of its status at the end of the probation period.

- d. Biennial Review. Each national medical specialty society, federal service, or professional interest medical association represented in the MSS Assembly will be required to reconfirm biennially that it continues to meet the criteria for representation. Organizations will be notified by the Governing Council of the time of their review and will be asked to submit appropriate documentation. Failure to participate in the biennial review process or to meet the established criteria will be reported to the MSS Governing Council for action.
- e. The Governing Council may terminate the representation of an organization in the MSS Assembly for failure to verify fulfillment of or to meet these criteria, in which case the organization can re-apply for representation.

3. National Medical Student Organizations.

- a. The following criteria have been developed for national medical student organizations to qualify for representation in the MSS Assembly, pursuant to AMA Bylaw 7.3.3.4.1:
 - i. The organization must be national in scope.
 - ii. A majority of the voting members of the organization must be medical students enrolled in educational programs as defined in AMA Bylaw 1.1.1.
 - iii. Membership in the organization must be available to all medical students, without discrimination.
 - iv. The purposes and objectives of the organization must be consistent with the AMA's purposes and objectives.
 - v. The organization's code of medical ethics must be consistent with the AMA's Principles of Medical Ethics.
- b. Application process. Interested national medical student organizations should submit to MSS staff a written application containing sufficient information to establish that the organization

meets the above criteria. The application must also include the following:

- i. The organization's charter, constitution, bylaws, and code of medical ethics.
- ii. A list of the sources of the organization's financial support, other than the dues of its medical student members.
- iii. A list or description of all of the organization's affiliations.
- iv. Such additional information as may be requested.

The MSS Governing Council shall review the application. If it recommends that the organization be granted representation in the MSS Assembly Meeting, the recommendation shall be submitted to the AMA Board of Trustees for review. If approved by the AMA Board of Trustees, the organization may be represented in the MSS Assembly Meeting by one MSS Delegate and one Alternate MSS Delegate.

- c. Biennial Review. Each national medical student organization represented in the MSS Assembly will be required to reconfirm biennially that it continues to meet the criteria for eligibility by submitting such information and documentation as may be required by the MSS Governing Council. Organizations will be notified by the Governing Council of the time of their review and will be asked to submit appropriate documentation. Failure to participate in the biennial review process or to meet the established criteria will be reported to the MSS Governing Council for action.
- d. The Governing Council may recommend discontinuance of the representation by a national medical student organization on the basis that the organization fails to meet the above criteria, has failed to maintain its responsibilities outlined in these Internal Operating Procedures, or has failed to attend the MSS Assembly Meeting. The recommendation shall be submitted to the AMA Board of Trustees for review. If approved by the AMA Board of Trustees, the representation of the national medical student organization in the MSS Assembly Meeting shall be discontinued.
- e. The MSS Delegate and Alternate MSS Delegate selected by each national medical student organization granted representation at the Assembly Meeting shall:
 - i. Have full voting rights including the right to vote in any elections at the conclusion of a two-year probationary period with regular attendance.

- ii. Not be eligible for election to any office in the MSS.
 - iii. Be able to present his or her organization's policies and opinions in the Assembly Meeting.
 - iv. Report on the actions of the MSS to the national medical student organization.
 - v. Cooperate in enhancing the MSS membership.
- f. MSS Delegates and Alternate MSS Delegates selected by national medical student organizations must meet the following criteria:
- i. Must be medical student members of the AMA in good standing.
 - ii. Should be chosen in a fair and equitable manner allowing open representation and medical student input.
 - iii. Must be certified in writing by the president, or appropriate staff person, of the organization they will be representing.
 - iv. Must represent the interests of their organization's medical student constituency.
4. Other Groups.
- a. The Association of American Medical Colleges – Organization of Student Representatives and the American Association of Colleges of Osteopathic Medicine – Council of Osteopathic Student Government Presidents are each entitled to one MSS Delegate and one Alternate MSS Delegate selected by the medical student members of the organization.
 - b. MSS Delegates and Alternate MSS Delegates selected from these organizations must meet the following criteria:
 - i. Must be medical student members of the AMA in good standing.
 - ii. Should be chosen in a fair and equitable manner allowing open representation and medical student input.
 - iii. Must be certified in writing by the president, or appropriate staff person, of the organization they will be representing.
 - iv. Must represent the interests of their organization's medical student constituency.

5. Official Observers.
 - a. National student organizations may apply to the MSS Governing Council for official observer status in the MSS Assembly. Applicants and official observers must demonstrate compliance with guidelines for official observers adopted by the MSS Assembly, and the Governing Council shall make a recommendation to the MSS Assembly concerning the application. The MSS Assembly will make the final determination on the conferring or continuation of official observer status.
 - b. Organizations with official observer status are invited to send one representative to observe the actions of the Assembly at all meetings of the MSS Assembly. Official observers have the right to speak and debate on the floor of the Assembly upon invitation from the Speaker. Official observers do not have the right to introduce business, introduce an amendment, make a motion, or vote.

D. Purposes of the Meeting. The purposes of the meeting shall be:

1. To hear such reports as may be appropriate.
2. To elect, at the Assembly meeting prior to the Interim Meeting of the AMA, the Chair-elect of the Governing Council of the MSS, and the Medical Student Trustee. To elect at the Assembly meeting prior to the Annual Meeting of the AMA, the remaining members of the Governing Council, with the exception of the Immediate Past Chair.
3. To adopt procedures for election of Medical Student Regional Delegates and Alternate Regional Delegates, consistent with AMA Bylaw 2.1.3.
4. To elect Medical Student Regional Delegates and Alternate Regional Delegates at Interim Meeting of the MSS.
5. To adopt resolutions for MSS policy and for submission to the House of Delegates of the AMA.
6. To conduct such other business as may properly come before the meeting.

E. Credentialing. The name of the duly selected MSS Delegate and Alternate MSS Delegate from each educational program, national medical specialty society, federal service, professional interest medical association, national medical student organization, and other group, and the representative from each official observer organization, should be received by the Medical Student Section staff of the AMA no later than 30 days prior to the Assembly Meeting in writing, as outlined in these Internal Operating Procedures. On the day of the opening of the Assembly Meeting, credentialing will take place, where voting members must

officially identify themselves to the Credentials Committee as having been duly selected by the AMA medical student members of their respective organizations. Identification will be required to receive a voting badge. Graduating or recently graduated senior medical students who have been credentialed as RFS Delegates or Alternate RFS Delegates in the representative assembly of the AMA Resident and Fellow Section shall not be allowed to serve as MSS Delegates or Alternate MSS Delegates in the MSS Assembly.

F. Participation.

1. Only duly selected MSS Delegates to the Assembly Meeting shall have the right to vote, but the meeting floor shall be open to all medical students and AMA members.
2. The Immediate Past Chair of the MSS Governing Council shall have the same speaking privileges, excluding the privilege to make a motion, in the MSS Assembly as any other member of the Governing Council if he or she is no longer a medical student.
3. The Presiding Officer shall be entitled to vote only to break a tie.

G. Procedure.

1. Agenda. At least 30 days prior to the Assembly Meetings, the agenda shall be sent to MSS Delegates and Alternate MSS Delegates. The order of business will be set by the Speakers prior to the meeting in accordance with MSS IOPs and MSS Policy. The Assembly may only change the order of business in accordance with the procedures set in the AMA Bylaws, MSS IOPs, and the parliamentary authority of the AMA outlined in B-11.1.
2. Rules of Order. The Assembly meeting shall be conducted pursuant to the established rules of procedure submitted by the Speakers and adopted by the Assembly. The parliamentary authority used by the AMA House of Delegates shall govern the Assembly Meeting of the MSS in all matters not outlined in the adopted rules of procedure mentioned above.
3. Quorum. Twenty-five percent of the MSS Delegates shall constitute a quorum, provided that at least ten percent of the MSS Delegates from each of the geographic regions are present. The regions are defined in MSS Internal Operating Procedures VII.A.1. For the purposes of defining a quorum, the MSS Delegate of each national medical specialty society, federal service, professional interest medical association, national medical student organization, and other group is considered part of the region representing the state in which his or her organization's headquarters are located.

H. Resolutions.

1. Any MSS region, state student section, medical school section, or individual medical student member may submit resolutions.
2. All resolutions submitted by medical students must be submitted electronically to the AMA Medical Student Section staff 50 days prior to the start of each Annual and Interim Meeting to be included in the MSS agenda.
 - a. Virtual Reference Committee. All reports and resolutions that meet submission criteria will be made available on the Virtual Reference Committee. Any AMA MSS member can comment on MSS business. Comments can be made on behalf of an individual, a medical student section at a medical school, a state medical student section, an organization represented in the Assembly, and/or an AMA MSS Region, provided sufficient authority exists for such commentary. All comments will be made available to the Reference Committee(s). The resolutions will be sent to all duly selected and certified MSS Delegates and Alternate MSS Delegates prior to the Assembly Meeting via the meeting Agenda and are debatable on the floor of the MSS Assembly.
3. Late Resolutions. Resolutions that are submitted after the deadline but before the beginning of the meeting shall require a two-thirds vote of the Assembly to be debatable on the floor. The Rules Committee shall make recommendations to the Assembly on whether they should be considered as business based on timeliness of the issue and temporality relative to the resolution submission deadline. Late resolutions approved for consideration shall be referred to the Reference Committee, and handled in the same manner as those resolutions introduced before the deadline.
 - a. Late Resolutions amending the MSS Internal Operating Procedures or proposing to amend AMA Bylaws shall not be considered.
4. Emergency Resolutions. Resolutions that are submitted after the beginning of the meeting shall require a three-fourths vote of the Assembly to be debatable on the floor. The motion to hear an emergency resolution is not debatable and only a statement on the timeliness of the resolution may be made. Emergency resolutions approved for consideration shall be debated on the floor of the Assembly without referral to the Reference Committee.
5. Resolutions approved for consideration as business shall require a simple majority vote of the Assembly for adoption, except those amending the MSS Internal Operating Procedures or proposing to amend the AMA Bylaws require approval by two-thirds of the members of the MSS Assembly present and voting.

6. Extraction of a resolution recommended for reaffirmation by the Reference Committee shall require a one-third vote of delegates present and voting.
7. Resolutions introduced by the Governing Council into the AMA-MSS Handbook shall be in the name of the AMA Delegate. Such resolutions may only be submitted when there is unanimous approval by all voting members of the Governing Council. They shall be considered by the MSS Assembly as a first priority of business.
8. Resolutions shall be submitted to the AMA House of Delegates at the next most appropriate meeting in the name of the MSS after receiving the approval of the MSS Assembly.

I. Convention Committees. The Convention Committees shall be appointed by the Governing Council unless otherwise stated in these procedures. These committees are to expedite the conduct of business at each meeting of the MSS Assembly. For each meeting, the Governing Council will appoint the following committees and any others that would facilitate the business of the Assembly.

1. **Credentials Committee.** An eight member Credentials Committee, composed of one member per region , unless there are no candidates from a region, and one Chair, shall be appointed by the Governing Council. The Committee shall be responsible for consideration of all matters relating to the registration and certification of MSS Delegates including credentialing MSS Delegates to MSS Assembly Meetings, verifying a quorum is present, and distributing ballots for elections. Disputes involving the credentialing of voting delegates will be investigated by the Credential Committee.
2. **Rules Committee.** A Rules Committee shall be composed of four At-Large Members and one Chair. The Rules Committee shall review late and emergency resolutions and make recommendations to the MSS Assembly on whether to consider them as business of the Assembly. The Rules Committee shall collect and tabulate ballots for MSS elections, and count hand votes during the Assembly Meeting as requested by the Speakers. The Rules committee is also responsible for ensuring election rules are followed in coordination with the MSS Speaker and Vice-Speaker.
3. **Reference Committee.** The committee shall conduct an open hearing on items of business referred to it (resolutions and reports) via the MSS Virtual Reference Committee, and make recommendations to the Assembly for disposition of its items of business through the preparation of Reference Committee report for consideration by the MSS Assembly.
4. **Parliamentary Procedures Committee.** The Parliamentary Procedures Committee members shall demonstrate a thorough

understanding of the parliamentary authority set forth by Internal Operating Procedure V.G.2 in order to assist students with parliamentary procedures throughout the Assembly meeting.

5. AMA House of Delegates Coordinating Committee. House Coordinating Committee members shall be appointed by the Governing Council to coordinate student testimony that will be presented at the AMA House of Delegates Reference Committee hearings. The Coordinators shall work with the AMA Delegate and Alternate AMA Delegate in the preparation and presentation of testimony for resolutions being transmitted by the MSS and additional items of relevance to the MSS.

XI. Appointments

A. Governing Council Responsibilities. It will be the responsibility of the Governing Council to make appointments of the medical student members of AMA Councils for confirmation by the AMA Board of Trustees and to other bodies of the AMA when requested. It is also the responsibility of the Governing Council to make recommendations for student representation to bodies such as the National Board of Medical Examiners, National Resident Matching Program, and others after the Governing Council has solicited applications from interested medical students.

B. Eligibility. Eligibility for Council and Liaison positions shall be pursuant to MSS Internal Operating Procedures VI.B.

C. Medical Student Representation on AMA Councils.

1. A medical student member of the AMA appointed by the MSS Governing Council with the concurrence of the Board of Trustees shall serve on each of the following AMA Councils:
 - a. Council on Constitution and Bylaws.
 - b. Council on Medical Education.
 - c. Council on Medical Service.
 - d. Council on Long Range Planning and Development.
 - e. Council on Scientific Affairs and Public Health.
2. A student is recommended by the MSS Governing Council to the AMA President-elect for consideration for appointment to the student seat on the Council on Ethical and Judicial Affairs.
3. A student is recommended by the MSS Governing Council to the AMA Board of Trustees for consideration for appointment to the student seat

on the Council on Legislation.

4. A student is recommended by the MSS Governing Council to the AMA Board of Trustees for consideration for appointment to the student seat on the Liaison Committee on Medical Education (an AMA/Association of American Medical Colleges joint committee).
5. In any discussion or selection of candidates for appointment to Council or Liaison positions, all Governing Council members who are candidates for the position under discussion or have significant conflicts of interest shall recuse themselves and be absent from this discussion.
 - a. The MSS Chair, or their designee, shall be responsible for ensuring a fair and thorough evaluation process by the Governing Council.
6. All applicants for Council and Liaison positions shall be informed of the Governing Council's decision to appoint or not appoint them as soon as the appointments are confirmed by the AMA Board of Trustees, President, or President Elect.
7. Terms. Students appointed to Councils shall serve for a one-year term with the exception of the student appointed to the Council on Ethical and Judicial Affairs, who will serve for a two-year term. If the medical student member of a Council ceases to be enrolled in an approved program, his or her service on the Council shall thereupon terminate, and the position shall be declared vacant.
8. Limitation on Total Years of Service. See MSS Internal Operating Procedures IV.G.

XII. Miscellaneous

- A. Financial Responsibility. The funding of the MSS Governing Council is appropriated by the AMA. A listing of all meetings attended by each member of the Governing Council and members of AMA-MSS funded by the section along with an account of pertinent actions taken, will be made available to MSS members upon request.

XIII. Dispute Resolution.

- A. All disputes of these Internal Operating Procedures shall be resolved by the AMA Board of Trustees (BOT) with provision for input from other parties as deemed necessary by the BOT, except in the following instances as defined elsewhere in these Internal Operating Procedures:
 1. All disputes involving Regional Delegate or Alternate Delegate elections shall be resolved by the MSS Governing Council.

2. All disputes involving Campaign Rules as related to the MSS shall be resolved by the MSS Speaker and Vice Speaker.

XIV. Amendments to the Internal Operating Procedures

- A. ~~Other Requirements.~~** Per AMA Bylaw 7.0.7, all rules, regulations, and procedures adopted by the MSS are subject to the approval of the Board of Trustees. Amendments to the Internal Operating Procedures may also be contingent upon corresponding changes to the AMA Bylaws, which require approval of two-thirds of the members of the AMA House of Delegates.

2016-2017 GC Action Item Request and Responses

Pursuant to policy 645.031MSS, "a list of all GC Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions. Additionally, the MSS should create an opportunity for the Governing Council to discuss three GC Action Item implementation status with interested students." Accordingly, below are the three Action Item Requests your Governing Council (GC) received during its 2016-2017 term and their respective responses.

- (1) Resolution Authorship & Template Revision
 - (2) Endorsement of Tom Price as Secretary of HHS
 - (3) Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act of 2017
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- 1) **GC Action Item Request Title:** Resolution Authorship & Template Revision
Submitted by Andrew Zureick (NBME Councilor) and Karthik Sarma (CMS Councilor) on September 20, 2016

Problem Summary: Currently, AMA-MSS resolutions introduced to the MSS-HOD by a school section, state delegation, or region will have the names of any individual authors represented by the larger group stricken in post-submission editing, but names of any individual authors not represented by the larger group are retained. Of the 30 resolutions heard at Annual 2016, 15 resolutions were introduced by a school/state/region without any mention of author names, seven resolutions were introduced by a region with individuals named outside that region, and one resolution (#28) was introduced by a region with individuals named both within and outside the region. I presume that -- more often than not -- the primary author of a resolution and other authors making significant contributions to a resolution are encompassed by a particular introducing school/state/region, and thus, their names are not affixed to the resolution on official any MSS-HOD documents if consensus from a larger group is successfully achieved prior to final submission.

Early on in my AMA-MSS involvement, I remember that MSS veterans were excited to share at a past Region 5 resolutions workshop that "resolutions adopted into policy count as publications for your CV," or at the very least, "resolutions adopted into policy can be included on your CV" as part of the pitch for writing them. Additionally, I learned that some schools recognize resolutions on the level of conference presentations and fund the primary/presenting author of a resolution for travel purposes, so this is another very compelling reason to be able to show the authors' names on a resolution more clearly. If, in the competitive resolution scoring and vetting process seeking support from larger groups is both rewarded and almost necessary now (only seven were introduced by individual authors at Annual 2016), aiming for this at the expense of being able to trace credit for one's own primary-authored resolution seems unusual. In this GC action item, I propose a simple solution that is used by the Michigan State Medical Society which allows both recognition of authors and recognition of the larger organization introducing the resolution.

Action Requested: Effective beginning at Annual 2017, I would like to ask our MSS Governing Council to revise the resolution template to have an "Authors" line and an "Introduced by" line, such that all author names are retained on the resolution and authorship credit is more easily traceable. Here is an example: goo.gl/z1zkbW. This

would allow both individuals represented by the larger organization as well as those outside of it to have their names affixed to the resolution. Furthermore, an additional suggestion would be to delineate further the individuals that actually authored the resolution from individuals who simply support its introduction to the assembly. The MSS would provide guidance that anyone who was simply a supporter and not a contributor during the writing process be listed on the "Introduced by" line and not on the "Authors" line. Please see 460.013MSS for more details on what our section believes constitutes authorship.

While this would be a deviation in formatting from AMA-HOD resolutions, and any external resolutions are ultimately introduced to the AMA by the Medical Student Section (without any mention of individuals), this would still be a nice internal change to formally allow resolution authors to be acknowledged for both authoring a resolution and going the extra mile to seek consensus from a larger group prior to the meeting, when saving official MSS meeting documents in their portfolios.

Existing AMA and AMA-MSS Policy: 460.013MSS Medical Ghostwriting: AMA-MSS will ask the AMA to educate, at appropriate intervals, physicians and physicians-in-training about the currently-defined differences between being an "author" and being a "contributor" as well as the varied potential for industry bias between these terms and the importance of self-identifying between these terms when submitting manuscripts for publication in accordance with the following text: (1) Authorship credit should be based on (a) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; (b) drafting the article or revising it critically for important intellectual content; and (c) final approval of the version to be published. Authors should meet conditions all three conditions. Those meeting fewer than all three criteria should be considered contributors.

645.031MSS Policy-making Procedures (8) Our MSS will release detailed resolution formatting rules and an easy to use template for resolution drafting, available on the MSS Resolution Resources page. Resolutions not meeting the formatting guidelines will be returned to the submitting author and not be accepted until properly formatted within the established deadlines.

Action Taken: Your Governing Council discussed this request and ultimately decided against taking the proposed action. The Governing Council did not find enabling authors to "trace" their "credit" to be a compelling justification for a significant deviation from AMA House of Delegates procedures and formatting. The purpose of writing a resolution is not intended to be padding one's resume; rather, resolutions are a conduit to having a tangible effect on AMA policies and endeavors. Your Governing Council also discourages the practice of schools making funding for meetings contingent on resolution authorship discussed in the action item. We feel that this encourages superfluous resolution-writing to the detriment of the MSS Assembly; again, the purpose of a resolution should be to change AMA policy, not acquire personal gain. Your Governing Council also finds it wholly unnecessary to add a new field to the resolution submission template to recognize "individuals who simply support [the resolution's] introduction to the assembly"- any AMA-MSS member is already able to indicate his or her support for a resolution via the Virtual Reference Committee, which is a preferable mechanism for this activity. As such, the Governing Council has maintained the same resolution template for Annual 2017 that was used for Interim 2016.

- 2) **GC Action Item Request Title:** Endorsement of Tom Price as Secretary of HHS
Submitted by Andrew Sayce, Vanderbilt University School of Medicine, on November 30, 2016

Problem Summary: The appointment of Representative Dr. Tom Price as secretary of HHS by President-elect Donald Trump has recently been endorsed by the AMA. As a student member of the AMA and future physician, I am concerned with the endorsement of an individual with a voting history related to health care that is at odds with the mission of the AMA "to promote the art and science of medicine and the betterment of public health. Items of particular concern include:

- Voted against expanding research on embryonic stem cells
- Voted against family planning assistance including access to birth control, planned parenthood, and elective abortions
- Voted against prohibiting job discrimination against LGBT individuals

Action Requested: I am unaware of how the AMA reached the conclusion that Tom Price will be an asset to the healthcare industry and more importantly, the health and wellbeing of the country. I would request:

- Educational information regarding how Rep. Dr. Price is seen as a positive choice for our industry and our mission in that industry
- An opportunity (open polling or referendum of current members) to assess the perspective of the larger body of the AMA, and specifically student voices as relates to this appointment

Existing AMA and AMA-MSS Policy: None cited.

Action Taken: Letter attached.

- 3) **GC Action Item Request Title:** Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act of 2017
Submitted by Anonymous on March 13, 2017

Problem Summary: In light of the current legislation limiting access to abortion services, many bills are being considered which are unconstitutional and restrict access to abortion for women.

Action Requested: The AMA-MSS should publicize the growing restrictions on women's health, including abortion services (especially in Texas) by promoting this bill (which does not necessarily endorse abortion services but is in line with AMA policy protecting the rights of women and use of abortion services). The AMA-MSS should also communicate with relevant stakeholders to address this issue.

Existing AMA and AMA-MSS Policy: H.99- (abortion policies)

Action Taken: Letter attached.



February 7, 2017

Dear Andrew,

Thank you for contacting the Governing Council about your concerns with the Dr. Tom Price nomination. As you are aware, health policy has been at the forefront of the national debate over the past few months. The AMA continues to be dedicated to being a part of that conversation going forward to protect the health and safety of our patients and physicians. Because of the need to move quickly on rapidly changing events in Washington, the AMA House of Delegates has decided to divest the power to endorse candidates for public office to the Board of Trustees with policy G-605.035, last reaffirmed at Annual 2012.

With regard to the Board's decisionmaking, I would like to highlight the response from the Chair of the Board of Trustees, Dr. Patrice Harris which gives the best explanation for their decision: <https://wire.ama-assn.org/ama-news/why-we-support-dr-price-lead-hhs>

"A mainstay through the years has been Dr. Price's commitment to seek out and hear the concerns expressed by the AMA and other physician organizations. Even so, our support for Dr. Price to lead HHS should not be taken as an endorsement of every policy position he has advocated."

Together with Congress, the new administration will play a prominent role in healthcare reform and your AMA remains committed to working with Dr. Price on "comprehensive health system reform, which achieves access to quality health care for all Americans while improving the physician practice environment." (H-165.847) Moving forward, the AMA emphasized the following core principles in a letter sent to Congress in early January:

- Ensure that individuals currently covered do not become uninsured and take steps toward coverage and access for all Americans.
- Maintain key insurance market reforms, such as pre-existing conditions, guaranteed issue, and parental coverage for young adults.
- Stabilize and strengthen the individual insurance market.
- Ensure that low/moderate income patients are able to secure affordable and adequate coverage.
- Ensure that Medicaid, CHIP and other safety net programs are adequately funded.
- Reduce regulatory burdens that detract from patient care and increase costs.
- Provide greater cost transparency throughout the health care system.
- Incorporate common sense medical liability reforms.
- Continue the advancement of delivery reforms and new physician-led payment models to achieve better outcomes, higher quality, and lower spending trends.

Your Governing Council has been in regular communication with the Board of Trustees and our Government Relations Advocacy Fellow, Christopher Clifford, on this and other topics related to the health policy discussions happening in the country today. Our goal has been to emphasize positions members of the MSS care about. We can assure you that the Board of Trustees has been very open to the views of medical students by scheduling calls with our Governing Council. Medical students have had a strong hand in creating policy that has influenced AMA in many important ways. Your continued work on our policy is the best way to shape the future of the AMA.



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Through the Medical Student Section our voice is reflected by our representatives in the HOD, on Councils and the Board of Trustees. With your help and with the input from others in the MSS, we will continue to communicate our views within the organization about issues most important to us.

We thank you for bringing your concerns to the Governing Council and encourage you to continue to be in communication with us so we can most effectively advocate for you.

A handwritten signature in black ink that reads "Christopher Libby". The signature is written in a cursive style with a large, prominent initial "C".

Christopher Libby, M.P.H.
Chair of the AMA Medical Student Section
M.D. Candidate | University of Massachusetts Medical School
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June 1, 2017

Thank you for taking the time to submit this action item request to your Governing Council. We have consulted with our Advocacy team and have drafted the following response.

The Equal Access to Abortion Coverage in Health Insurance (EACH Women) Act of 2017 (H.R. 771) is a bill introduced by Representative Barbara Lee from California. Here is the bill's summary from congress.gov:

This bill requires the federal government: (1) to ensure coverage for abortion care in public health insurance programs including Medicaid, Medicare, and the Children's Health Insurance Program (CHIP); (2) as an employer or health plan sponsor, to ensure coverage for abortion care for participants and beneficiaries; and (3) as a provider of health services, to ensure that abortion care is made available to individuals who are eligible to receive services.

The federal government may not prohibit, restrict, or otherwise inhibit insurance coverage of abortion care by state or local governments or by private health plans. State and local governments may not prohibit, restrict, or otherwise inhibit insurance coverage of abortion care by private health plans.

First, let us make one point of clarification. The AMA-MSS does not take any formal advocacy positions itself. Our Advocacy department only follows policy that is passed in the House of Delegates. Therefore, we must consult with this department on all advocacy related issues before moving forward.

However, you are correct in stating that we have relevant AMA-HOD policy regarding this issue. Specifically, H-5.998 (Public Funding of Abortion Services) states that we oppose any legislative proposals that "utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population."

However, the decision to support or not support a specific piece of legislation in Congress is a very complicated matter. That is why we have an entire office of professional full time lobbyists and lawyers helping us to navigate the political landscape. When talking to the Advocacy team, they have informed us that this bill only has minority party support, which pretty much guarantees that the bill does not have the votes to make it through the House. Moreover, no cosponsors or outside organizations have reached out to our Advocacy team asking for us to comment. This shows us that even the bill cosponsors know that the bill will likely not pass, so they are not putting time and energy into drumming up support. Most importantly however, our Advocacy team believes that commenting on this bill in the current political climate will do more harm than good for our organization. The AMA has many issues it is fighting for. If we make enemies on this particular topic then it may hurt the rest of our advocacy initiatives.

Again thank you for contacting your Governing Council about this matter. We will be sure to track the EACH Women Act throughout the 115th Congress and will revisit the issue if a major political change or event occurs.



American Medical Association

Medical Student Section

Thank you for educating yourself on this topic and bringing it to our attention. If you have any questions or comments please feel free to email our Government Relations Advocacy Fellow at christopher.clifford@ama-assn.org

2016-2017 AMA- MSS Governing Council

Reference Committee on Amendments to Constitution and Bylaws

CEJA Report 1 - Ethical Practice in Telemedicine

The Council on Ethical and Judicial Affairs recommends that Opinions E-5.025, "Physician Advisory or Referral Services by Telecommunication," and E-5.027, "Use of Health-Related Online Sites," be amended by substitution as follows and the remainder of this report filed:

Innovation in technology, including information technology, is redefining how people perceive time and distance. It is reshaping how individuals interact with and relate to others, including when, where, and how patients and physicians engage with one another.

Telehealth and telemedicine span a continuum of technologies that offer new ways to deliver care. Yet as in any mode of care, patients need to be able to trust that physicians will place patient welfare above other interests, provide competent care, provide the information patients need to make well-considered decisions about care, respect patient privacy and confidentiality, and take steps to ensure continuity of care. Although physicians' fundamental ethical responsibilities do not change, the continuum of possible patient-physician interactions in telehealth/telemedicine give rise to differing levels of accountability for physicians.

All physicians who participate in telehealth/telemedicine have an ethical responsibility to uphold fundamental fiduciary obligations by disclosing any financial or other interests the physician has in the telehealth/telemedicine application or service and taking steps to manage or eliminate conflicts of interests. Whenever they provide health information, including health content for websites or mobile health applications, physicians must ensure that the information they provide or that is attributed to them is objective and accurate.

Similarly, all physicians who participate in telehealth/telemedicine must assure themselves that telemedicine services have appropriate protocols to prevent unauthorized access and to protect the security and integrity of patient information at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who participate in the telehealth/telemedicine service consistent with their individual roles.

Physicians who respond to individual health queries or provide personalized health advice electronically through a telehealth service in addition should:

- (a) Inform users about the limitations of the relationship and services provided.
- (b) Advise site users about how to arrange for needed care when follow-up care is indicated.
- (c) Encourage users who have primary care physicians to inform their primary physicians about the online health consultation, even if in-person care is not immediately needed.

Physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. In the context of telehealth/telemedicine they further should:

- (d) Be proficient in the use of the relevant technologies and comfortable interacting with patients and/or surrogates electronically.

(e) Recognize the limitations of the relevant technologies and take appropriate steps to overcome those limitations. Physicians must ensure that they have the information they need to make well-grounded clinical recommendations when they cannot personally conduct a physical examination, such as by having another health care professional at the patient's site conduct the exam or obtaining vital information through remote technologies.

(f) Be prudent in carrying out a diagnostic evaluation or prescribing medication by:

(i) establishing the patient's identity;

(ii) confirming that telehealth/telemedicine services are appropriate for that patient's individual situation and medical needs;

(iii) evaluating the indication, appropriateness and safety of any prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and

(iv) documenting the clinical evaluation and prescription.

(g) When the physician would otherwise be expected to obtain informed consent, tailor the informed consent process to provide information patients (or their surrogates) need about the distinctive features of telehealth/telemedicine, in addition to information about medical issues and treatment options.

Patients and surrogates should have a basic understanding of how telemedicine technologies will be used in care, the limitations of those technologies, the credentials of health care professionals involved, and what will be expected of patients for using these technologies.

(h) As in any patient-physician interaction, take steps to promote continuity of care, giving consideration to how information can be preserved and accessible for future episodes of care in keeping with patients' preferences (or the decisions of their surrogates) and how follow-up care can be provided when needed. Physicians should assure themselves how information will be conveyed to the patient's primary care physician when the patient has a primary care physician and to other physicians currently caring for the patient.

Collectively, through their professional organizations and health care institutions, physicians should:

(i) Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.

(j) Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.

(k) Routinely monitor the telehealth/telemedicine landscape to:

(i) identify and address adverse consequences as technologies and activities evolve; and

(ii) identify and encourage dissemination of both positive and negative outcomes.

MSS Position: **Support**

MSS Policy Justifying Position: 480.010MSS Web-Based Tele-Health Initiatives and Possible Interference with the Traditional Physician-Patient Relationship

CEJA Report 3 - CEJA's Sunset Review of 2006 House Policies

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

MSS Position: **Support**

MSS Policy Justifying Position: Formal support for H-460.972 Fraud and Misrepresentation in Science

001 - Support for Persons with Intellectual Disabilities Transitioning to Adulthood

RESOLVED, That our American Medical Association encourage appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.

MSS Position: **Support**

MSS Policy Justifying Position: 25.002MSS Transitional Support for Individuals with Autism Spectrum Disorders into Adulthood (HOD resolution is MSS-authored)

002 - Clarification of Medical Necessity for Treatment of Gender Dysphoria

RESOLVED, That our American Medical Association recognize that treatment for gender dysphoria should be determined by shared decision making between patient and physician, consistent with generally-accepted standards of medical and surgical practice; and be it further

RESOLVED, That our AMA amend H-185.950 by addition and deletion to read as follows:

Removing Financial Barriers to Care for Transgender Patients H-185.950

Our AMA supports public and private health insurance coverage for treatment of gender identity disorder dysphoria as recommended by the patient's physician.

MSS Position: **Support**

MSS Policy Justifying Position: 65.012MSS Removing Barriers to Care for Transgender Patients; 65.017MSS Lesbian, Gay, Bisexual, and Transgendered Patient-Specific Training Programs for Healthcare Providers; 65.019MSS Conforming Birth Certificate Policies to Evolving Medical Standards for Transgender Patients; 460.012MSS Encouraging Research Into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients

003 - Supporting Autonomy for Patients with Differences of Sex Development

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

MSS Position: **Support**; substitute resolved clause offered:

RESOLVED, That our American Medical Association opposes medically unnecessary surgeries in individuals born with differences of sex development until the patient can actively participate in decision-making.

MSS Policy Justifying Position: 245.020MSS Supporting Autonomy for Patients with Differences of Sex Development (HOD resolution is MSS-authored); substitute resolved clause was developed with authors of original resolution to address concerns raised about the "unethical" language

004 - Targeted Education to Increase Organ Donation

RESOLVED, That our American Medical Association study potential educational efforts on the issue of organ donation tailored to demographic groups with low organ donation rates.

MSS Position: **Support**

MSS Policy Justifying Position: 370.016MSS Targeted Education to Increase Organ Donation (HOD resolution is MSS-authored)

005 - Clarification of Medical Necessity for Treatment of Gender Dysphoria

RESOLVED, That our American Medical Association recognize that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; and be it further

RESOLVED, That our AMA advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria.

MSS Position: **Support**

MSS Policy Justifying Position: 65.012MSS Removing Barriers to Care for Transgender Patients; 65.017MSS Lesbian, Gay, Bisexual, and Transgendered Patient-Specific Training Programs for Healthcare Providers; 65.019MSS Conforming Birth Certificate Policies to Evolving Medical Standards for Transgender Patients; 460.012MSS Encouraging Research Into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients

008 - Updating Sexual Orientation and Gender Identity Policies

RESOLVED, That our American Medical Association amend the title and text of HOD Policy H-160.991, Health Care Needs of the Homosexual Population, by addition and deletion to read as follows:

Health Care Needs of the ~~Homosexual~~ Lesbian Gay Bisexual and Transgender Populations

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities ~~and behavior~~ enhances the ability to render optimal patient care in health as well as in illness. In the case of the ~~homosexual~~ lesbian gay bisexual and transgender (LGBT) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBT ~~true since unrecognized homosexuality by the physician or the patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems. With the help of the gay and lesbian community and through a cooperative effort between physician and the homosexual patient effective progress can be made in treating the medical needs of this particular segment of the population;~~ (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of homosexuality LGBT Health and the need to elicit relevant gender and sexuality information from our patients ~~to take an adequate sexual history;~~ these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of their ~~homosexual~~ LGBT patients; (iii) encouraging the development of educational programs in LGBT Health ~~for homosexuals to acquaint them with the diseases for which they are at risk;~~ (iv) encouraging physicians to seek out local or national experts in the health care needs of ~~gay men and lesbians~~ LGBT people so that all physicians will achieve a better understanding of the medical needs of this these populations; and (v) working with ~~the gay and lesbian community~~ LGBT communities to offer physicians the opportunity to better understand the medical needs of ~~homosexual and bisexual~~ LGBT patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity ~~that is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her homosexual orientation.~~

2. Our AMA will ~~(a)~~ collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex ~~exclusively~~ with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and ~~(b) support our partner medical organizations in educating women who have sex exclusively with women on the need for regular cancer screening exams, the risk for sexually transmitted infections, and the~~ (iii) appropriate safe sex techniques to avoid that risk the risk for sexually transmitted diseases.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to use the results of the survey being conducted in collaboration with the Gay and Lesbian Medical Association to serve as a needs assessment in developing such tools and online continuing medical education (CME) programs with the goal of increasing increase physician competency on ~~gay, lesbian, bisexual, and transgender~~ LGBT health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to ~~gay men and lesbians.~~ LGBT people.; and be it further

RESOLVED, That our AMA amend the title of HOD Policy D-65.996, Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population, to: Nondiscriminatory Policy for the Health Care Needs of the Homosexual LGBT Populations; and be it further

RESOLVED, That our AMA amend the title of HOD Policy H-65.976, Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population, to: Nondiscriminatory Policy for the Health Care Needs of the Homosexual LGBT Populations.

MSS Position: **Support**

MSS Policy Justifying Position: 65.008MSS Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population; 65.010MSS Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender Health Issues on Medical School Campuses; 65.012MSS Removing Barriers to Care for Transgender Patients; 65.017MSS Lesbian, Gay, Bisexual, and Transgendered Patient-Specific Training Programs for Healthcare Providers; 65.002MSS Nondiscrimination Based on Sexual Orientation; 75.007MSS Preservation of HIV and STD Prevention Programs Involving Safer Sex Strategies and Condom Use; 310.041MSS Improving Primary Care Residency Training to Advance Health Care for Gay, Lesbian, Bisexual, and Transgender Patients

009 – Physician Decision Making

RESOLVED, That our American Medical Association advocate that in order to ensure quality of care given to patients, physicians, regardless of employment status, must maintain overall responsibility and leadership in decisions affecting the health care received by patients.

MSS Position: **Support**

MSS Policy Justifying Position: 160.014MSS Recognizing the Important Role of Physician Extenders in the Multidisciplinary Patient Care Team; formal support for H-160.919 Principles of the Patient-Centered Medical Home

016 – Social Media Trends and the Medical Profession

RESOLVED, That our American Medical Association ask the Council on Ethical and Judicial Affairs to reconsider AMA Ethical Opinion E-9.124, Professionalism in the Use of Social Media.

MSS Position: **Support**

MSS Policy Justifying Position: 140.019MSS Supporting the Establishment of Guidelines Regarding Online Professionalism; 140.020MSS: Increasing Physician Presence in Online Social Networks

Reference Committee A – Medical Service

CMS Report 3 – Paid Sick Leave

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 202-A-15 and that the remainder of the report be filed:

1. That our American Medical Association reaffirm Policy H-420.979 supporting voluntary employer policies that provide employees with job security and continued availability of health plan benefits in the event leave becomes necessary due to medical conditions.
2. That our AMA recognize the public health benefits of paid sick leave and other discretionary paid time off.
3. That our AMA support voluntary employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member.
4. That our AMA support employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome.

MSS Position: **Support Recommendations 1, 2, and 3; oppose Recommendation 4**

MSS Policy Justifying Position: 440.050MSS Measuring the Effect of Paid Sick Leave (PSL) on Health-Care Outcomes; 270.003MSS Broadening Access to Paid Family Leave to Improve Health Outcomes and Health Disparities; 310.049MSS Equal Paternal and Maternal Leave for Medical Residents

101 – Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraceptive Placement

RESOLVED, That our American Medical Association recognize the practice of immediate postpartum and post-abortive long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies; and be it further

RESOLVED, That our AMA support the coverage of immediate postpartum long-acting reversible contraception device and placement by Medicaid, Medicare, and private insurers, and that this service be billed separately from the obstetrical global fee; and be it further

RESOLVED, That our AMA encourage relevant specialty organizations to provide training for physicians regarding (1) patients who are eligible for immediate postpartum long-acting reversible contraception, and (2) immediate postpartum long-active reversible contraception placement protocols and procedures.

MSS Position: **Support**

MSS Policy Justifying Position: 75.013MSS Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraception Placement (HOD resolution is MSS-authored)

103 – Direct Primary Care

RESOLVED, That our American Medical Association work to include Direct Primary Care as a qualified Health Savings Account medical expense by the Internal Revenue Service.

MSS Position: **Support**

MSS Policy Justifying Position: 165.009MSS Evaluation of the Principles of the Health Care Access Resolution; 165.011MSS Medicaid Reform and Coverage for the Uninsured; 160.018MSS Investigating Cost-Saving, Equitable Care in Direct Practice Medicine; formal support for H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured

105 – Restore Medicare Dual Eligible Payments

RESOLVED, That our American Medical Association urge Congress to pass legislation to require that state Medicaid programs cover the cost-sharing amounts for patients insured by both Medicare and Medicaid.

MSS Position: **Support**

MSS Policy Justifying Position: 165.012 MSS Covering the Uninsured as AMA's Top Priority; 165.015MSS Maintaining Insurance Coverage and Empowering State Choice; 65.016MSS Elimination of Health Care Disparities Resulting from Insurance Status; 165.011MSS Medicaid Reform and Coverage for the Uninsured: Beyond Tax Credits; formal support for H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured; formal support for H-165.855 Medical Care for Patients with Low Incomes

106 – Education About Pre-Exposure Prophylaxis for HIV

RESOLVED, That our American Medical Association continue its efforts to educate physicians about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines; and be it further

RESOLVED, That our AMA advocate that all insurers be required to cover the costs associated with the administration of PrEP (Directive to Take Action); and be it further

RESOLVED, That our AMA work with governmental officials to study the feasibility of providing PrEP free of charge to high risk individuals.

MSS Position: **Support**

MSS Policy Justifying Position: **Caucus vote taken to support (2/3)**; 20.005MSS Drug Availability; 20.006MSS AIDS Prevention Through Educational Programs; 20.018MSS Averting Antiretroviral Treatment Rationing in the United States – Strengthening the AIDS Drug Assistance Program; 250.011MSS Low Cost Drugs to Poor Countries During Times of Pandemic Health Crisis

111 – Single Payer Health Care Study

RESOLVED, That our American Medical Association research and analyze the benefits and difficulties of a single-payer health care system in the United States with consideration of the impact on economic and health outcomes and on health disparities.

MSS Position: **Support**

MSS Policy Justifying Position: **Caucus vote taken to confirm that MSS has sufficient policy to support (simple majority)**; 165.017MSS Support for State-By-State Universal Health Care; 165.012MSS Covering the Uninsured as AMA's Top Priority; 165.009MSS Evaluation of the Principles of the Health Care Access Resolution; 165.007MSS Steps in Advancing towards Affordable Universal Access to Health Insurance;

113 – Support for Equal Health Care Access for Eating Disorders

RESOLVED, That our American Medical Association modify Policy H-185.974, Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs, by addition and deletion to read as follows:

Our AMA supports parity of coverage for mental illness, alcoholism and substance use, and will advocate against exclusions from coverage of specific diagnoses such as eating disorders.; and be it further

RESOLVED, That our AMA advocate that the treatment of eating disorders is specifically included in medical benefits programs.

MSS Position: **Support**

MSS Policy Justifying Position: 180.018MSS Support for Equal Healthcare Access for Eating Disorders; 60.008MSS School-Based Prevention of Eating Disturbances in Adolescents; formal support for H-345.992 Health Insurance Coverage of Psychiatric Illness; formal support for H-185.974 Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs; formal support for H-185.986 Nondiscrimination in Health Care Benefits; formal support for H-150.965 Eating Disorders

118 – Addressing the Health and Health Care Access Issues of Incarcerated Individuals

RESOLVED, That our American Medical Association advocate for an adequate number of health care providers to address the medical and mental health needs of incarcerated individuals; and be it further

RESOLVED, That our AMA advocate for an adequate number of primary care and mental health personnel to provide adequate health care treatment to civilly committed (designated to correctional institutions), incarcerated, or detained individuals; and be it further

RESOLVED, That our AMA advocate for the reversal of the "inmate exclusion clause" such that detainees and inmates who are eligible for state and federally funded insurance programs in the community maintain their eligibility when they are pre-trial, detained up to one year, and within one year of release to improve health outcomes in this vulnerable populations and decrease its burden of racial and ethnic health care disparities.

MSS Position: **Support Resolved 1 and Resolved 2**

MSS Policy Justifying Position: 345.006MSS Reduced Incarceration and Improved Treatment of Individuals with Mental Illness or Illicit Drug Dependence; 505.006MSS Smoking in Prisons; 315.004MSS Implementing the Use of EHR in Jail Health Services; 20.010MSS Comprehensive HIV Programs in Correctional Facilities; 95.006MSS Comprehensive Evidence-Based Drug Treatment in Prisons; formal support for H-430.988 Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities

Reference Committee B – Legislation and Advocacy

BOT Report 6 – Council on Legislation Sunset Review of 2006 House Policies

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated and the remainder of this report be filed.

MSS Position: **Support**

MSS Policy Justifying Position: 120.005MSS Tracking and Punishing Distributors of Counterfeit Pharmaceuticals; 160.014MSS Recognizing the Important Role of Physician Extenders in the Multidisciplinary Patient Care Team; 160.015MSS Physician Extenders; 435.007MSS U.S. Medical Liability Crisis and the Impact on Clinical Medical Education; 460.017MSS Maximizing Patient Outcomes through Public Access to all Past, Present and Future Clinical Trials; formal support for H-120.960 Protection for Physicians Who Prescribe Pain Medication; formal support for H-315.983 Patient Privacy and Confidentiality

BOT Report 10 – Electronic Health Records and Meaningful Use

The Board of Trustees recommends that the following be adopted in lieu of Resolutions 224-A-15, 227-A-15, and 228-A-15, and Substitute Resolution 224-A-15 and the remainder of the report be filed.

1. That our American Medical Association continue to work with the Centers for Medicare & Medicaid Services and other relevant stakeholders to allow for partial credit for eligible professionals in the Meaningful Use and Merit-Based Incentive payment programs.
2. That our AMA compile and continue to educate physicians on the available guidance related to different types of EHRs, system downtime, and technology failures, including mitigation strategies, continuity training solutions, and contracting solutions.

MSS Position: **Support**

MSS Policy Justifying Position: 160.016MSS Promoting Internet-Based Electronic Health Records and Personal Health Records; 315.003MSS Enabling a Contiguous, National Electronic Health Record Network; formal support for H-478.995 National Health Information Technology; formal support for D-478.995 National Health Information Technology; formal support for D-478.994 Health Information Technology; D-478.996 Information Technology Standards and Costs

BOT Report 12 – Reducing Gun Violence

The Board of Trustees recommends that policy H-145.996 be amended by addition and deletion to read as follows in lieu of Substitute Recommendation, BOT Report 7-A-14, Substitute Resolution 215-A-14 and Resolutions 215-A-14 and 224-A-14, and that the remainder of this report be filed.

H-145.996 Handgun Availability

The AMA (1) advocates a waiting period and background check for all firearm purchases ~~handgun purchasers~~; (2) encourages legislation that enforces a waiting period and background check for all firearm purchases ~~handgun purchasers~~; and (3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

MSS Position: **Support**

MSS Policy Justifying Position: 145.001MSS Handgun Violence; 145.012MSS Use of Individualized Violence Risk Assessments in Reporting of Mental Health Professionals for Firearm Background Checks; 145.013 Strengthening our Gun Policies on Background Checks and the Mentally Ill

BOT Report 13 – Restrictive Covenants in Physician Contracts

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 203-A-15 and that the remainder of the report be filed:

1. That our American Medical Association provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies.

MSS Position: **Support**

MSS Policy Justifying Position: 310.020MSS Restrictive Covenants in Training Programs

BOT Report 19 – Pain as the Fifth Vital Sign

The Board recommends that the following be adopted in lieu of Resolution 707-A-15, and that the remainder of the report be filed.

1. That our AMA work with The Joint Commission to promote evidence-based, functional and effective pain assessment and treatment measures for accreditation standards;

2. That our AMA reaffirm D-160.981, "Promotion of Better Pain Care," H -185.931, "Coverage for Chronic Pain Management," and D-120.971, "Promoting Pain Relief and Preventing Abuse of Controlled Substances."

3. That our AMA strongly support timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient's access to care.

MSS Position: **Support**

MSS Policy Justifying Position: 270.009MSS Protection for Physicians who Prescribe Pain Medication; 100.012MSS Support for the Use of Pain Contracts; 440.023MSS Support for a National Center on Pain Research; formal support for Protection for Physicians Who Prescribe Pain Medication H-120.960

BOT Report 22 – Study OTC Availability of Naloxone

The Board of Trustees recommends that the following be adopted in lieu of Resolution 909-I-15, and that the remainder of the report be filed.

1. That our American Medical Association reaffirm Policy D-95.987, "Prevention of Opioid Overdose."
2. That our AMA support legislative and regulatory efforts that increase access to naloxone, including collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
3. That our AMA support efforts that enable law enforcement agencies to carry and administer naloxone.
4. That our AMA encourage physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
5. That our AMA encourage private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
6. That our AMA support liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.

MSS Position: **Support**

MSS Policy Justifying Position: 100.013MSS OTC Availability of Naloxone; 100.007MSS Naloxone Administration and Heroin Overdose; 100.010MSS Promoting Prevention of Fatal Opioid Overdose

201 – Repeal of Anti-Kickback Safe Harbor for Group Purchasing Organizations

RESOLVED, That our American Medical Association support the repeal of the "Anti-Kickback Safe Harbor" for Group Purchasing Organizations.

MSS Position: **Support**

MSS Policy Justifying Position: 100.015MSS Addressing the U.S. Drug Shortage Crisis (HOD resolution is MSS-authored)

202 – Supporting Legislation to Create Student Loan Savings Accounts

RESOLVED, That our American Medical Association advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

MSS Position: **Support**

MSS Policy Justifying Position: 305.053MSS Expanding and Strengthening AMA Advocacy on Medical Student Debt; 305.001MSS Medical Student Loan Program; 305.052MSS Reduction in Student Loan Interest Rates; formal support for D-305.993 Medical School Financing, Tuition, and Student Debt

203 – Opposition to Disclosure of Drug Use and Addiction Treatment History in Public Assistance Programs

RESOLVED, That our American Medical Association amend Policy H-270.966 by insertion and deletion as follows:

H-270.966 Disclosure of Drug Use and Addiction Treatment History in Public Housing Applications Assistance Programs

The AMA opposes ~~Section 301 d (the Grams Amendment of the Public Housing Reform and Responsibility Act of 1997), which authorizes public housing agencies to require~~ a) requiring that housing applicants consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance, and seeks its removal and b) requiring applicants and/or beneficiaries of Temporary Assistance for Needy Families (TANF, “welfare”) and/or the Supplemental Nutrition Assistance Program (SNAP, “food stamps”) to disclose medical information, including alcohol and other drug use or treatment for addiction, or to deny assistance from these programs based on substance use status.

MSS Position: **Support**

MSS Policy Justifying Position: 270.028MSS Opposition to Disclosure of Drug Use and Addiction Treatment History in Public Assistance Programs (HOD resolution is MSS-authored)

205 – AMA Support for Justice Reinvestment Initiatives

RESOLVED, That our American Medical Association support legislation aimed at improving risk assessment tools, expanding jail diversion and jail alternative programs, streamlining case processing, and increasing access to reentry and treatment programs.

MSS Position: **Support**

MSS Policy Justifying Position: 270.029MSS AMA Support for Justice Reinvestment Initiatives (HOD resolution is MSS-authored)

208 – Attorney Ads on Drug Side Effects

RESOLVED, That our American Medical Association seek by legislation and/or regulation a requirement that attorney commercials which may cause patients to discontinue medically necessary medications have appropriate warnings that patients should not discontinue medications without seeking the advice of their physician.

MSS Position: **Support**

MSS Policy Justifying Position: 105.001MSS Drug Advertising to the Public; formal support for H-105.988 Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices

212 – Interstate Medical Licensure Compact

RESOLVED, That our American Medical Association oppose the Federation of State Medical Boards' Interstate Medical Licensure Compact.

MSS Position: **Oppose**

MSS Policy Justifying Position: 480.014MSS Support of Interstate Medical Licensure Compacts; 480.010MSS Web-Based Tele-Health Initiatives and Possible Interference with the Traditional Physician-Patient Relationship; 290.002MSS Interstate Medicaid Cooperation

215 – Tax Exemptions for Feminine Hygiene Products

RESOLVED, That our American Medical Association support legislation to remove all sales tax on feminine hygiene products.

MSS Position: **Support**

MSS Policy Justifying Position: **Caucus vote to support (2/3)**

219 – Dry Needling by Physical Therapists and Other Non-Physician Providers

RESOLVED, That our American Medical Association develop policy on the issue of dry needling practice by non-physician groups including physical therapists, in order to guide this conversation at the national level; and be it further

RESOLVED, That AMA policy on the practice of dry needling by physical therapists and other non-physician groups include, at a minimum, the benchmarking of training standards to already existing standards of training, certification, and continuing education that exist for the practice of acupuncture.

MSS Position: **Support**

MSS Policy Justifying Position: 160.015MSS Physician Extenders; 295.135MSS Increasing Awareness of the Benefits and Risks Associated with Complementary and Alternative Medicine

220 – Managing Controlled Substance High Utilizer Patients

RESOLVED, That our American Medical Association amend policy H-95.947 by addition to read as follows:

Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947

Our AMA: (1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states, pharmacies, and clinicians; (2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities; (3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances; (4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions across state boundaries; and (5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians; and be it further

RESOLVED, That, consistent with the American Medical Association (AMA) policies H-95.945 and H-95.947, the AMA implement a coordinated effort among all state medical societies to advocate for an interstate compact whereby pharmacies and clinicians can have access to Prescription Drug Monitoring Programs controlled substances dispensing data across state boundaries.

MSS Position: **Support**

MSS Policy Justifying Position: 120.009MSS Restrictions on Use of Physician Prescribing Data for Commercial Purposes; 315.001MSS Patient Confidentiality and Government Investigations; formal support for H-120.960 Protection for Physicians Who Prescribe Pain Medication

221 – Assurance and Accountability for EPA's State Level Agencies

RESOLVED, That our American Medical Association lobby the federal government to implement and enforce a requirement that the United States Environmental Protection Agency (EPA) conduct regular quality assurance reviews of state agencies that are delegated to enforce EPA regulations.

MSS Position: **Support**

MSS Policy Justifying Position: 135.002MSS Environmental Protection; 170.001MSS Prevention & Health Education

224 – Ocular Injuries from Air Guns

RESOLVED, That our American Medical Association support legislation that requires air guns sold or transferred by a dealer or in a private sale to be packaged with appropriate and safe protective eyewear and a tamper-resistant mechanical lock or other safety device; and be it further

RESOLVED, That our AMA support legislation that prohibits a minor from using an air gun on any public or private property unless the minor and persons known to be in range of the air gun are wearing appropriate and safe protective eyewear; and be it further

RESOLVED, That our AMA support legislation that requires that any civil liability of a minor due to the minor's use of an air gun resulting in the injury or death of another person shall be imposed upon the parent or guardian having custody and control of the minor for all purposes of civil damages and that a warning of this potential liability be attached to the air's gun's tamper-resistant mechanical lock or other safety device.

MSS Position: **Support**

MSS Policy Justifying Position: 10.009MSS Use of Protective Eyewear by Young Athletes; 145.004MSS Prevention of Unintentional Firearm Accidents in Children

225 – Fraudulent Use of Prescriptions

RESOLVED, That our American Medical Association promote the efforts for state run electronic Prescription Monitoring Programs to allow individual physicians to access records of their prescribing of opioids, for their entire panel of patients, including patient names and prescription information; and be it further

RESOLVED, That our AMA promote the recommendation to provide a clear pathway for individual physicians to communicate about any possible fraudulent use of their prescriptions.

MSS Position: **Support**

MSS Policy Justifying Position: 120.009MSS Restrictions on Use of Physician Prescribing Data for Commercial Purposes; 315.001MSS Patient Confidentiality and Government Investigations; 270.009MSS Protection for Physicians who Prescribe Pain Medication; formal support for H-120.960 Protection for Physicians Who Prescribe Pain Medication; formal support for H-95.990 Drug Abuse Related to Prescribing Practices

228 – No Legislative Pill Counts

RESOLVED, That our American Medical Association oppose legislation that restricts a prescription for any controlled substance, including opioids, based on a specific number of pills or for a specific period of time less than 30 days.

MSS Position: **Support**

MSS Policy Justifying Position: 100.012MSS Support for the Use of Pain Contracts; formal support for H-120.960 Protection for Physicians Who Prescribe Pain Medication

230 – Veterans Health Administration Transparency and Accountability

RESOLVED, That our American Medical Association adopt as policy that the Veterans Health Administration be required to report publicly on all aspects of its operation, including quality, safety, patient experience, timeliness, and cost effectiveness; and be it further

RESOLVED, That our AMA actively support federal legislation to achieve this reform of Veterans Health Administration transparency and accountability.

MSS Position: **Support**

MSS Policy Justifying Position: 520.005MSS Ensuring High Quality Care for All Veterans and Their Families; 155.003MSS Price Transparency in Health Care; formal support for H-510.985 Access to Health Care for Veterans; formal support for H-510.991 Veterans Administration Health System; formal support for H-510.995 Budgetary and Management Needs of the Veterans Health Administration; formal support for D-510.999 Veterans Health Administration Health Care System; formal support for H-373.998 Patient Information and Choice

232 – Closing Gaps in Prescription Drug Monitoring Programs

RESOLVED, That our American Medical Association advocate for the inclusion of all controlled substance prescriptions, regardless of their private, public, military or governmental source, in the reporting requirements for Prescription Drug Monitoring Programs (PDMP); and be it further

RESOLVED, That our AMA advocate for the inclusion of all controlled substances administered or dispensed by opioid treatment programs in the reporting requirements for Prescription Drug Monitoring Programs (PDMP).

MSS Position: **Support**

MSS Policy Justifying Position: 120.009MSS Restrictions on Use of Physician Prescribing Data for Commercial Purposes

237 – Collective Bargaining for Physicians

RESOLVED, That our American Medical Association support the right of all physicians to form local and/or regional negotiating units consistent with our medical ethics and professionalism for the purpose of collectively bargaining with employers, insurers, government, or managed care entities on issues of health care quality, patient rights, and physician rights; and be it further

RESOLVED, That our AMA amend our AMA Code of Medical Ethics so that our policy will oppose any affiliation of physician negotiating units with labor unions or other entities unless such affiliation includes a right to strike.

MSS Position: **Support**

MSS Policy Justifying Position: 530.017MSS Creation of a National Labor Organization for Physicians; 310.035MSS Past and Future Policy Suggestions to Improve the National Resident Matching Program

239 – Opposition to the Department of Veterans Services Proposed Rulemaking on APRN Practices

RESOLVED, That our American Medical Association express to the U.S. Department of Veterans Affairs (VA) that the plan to substitute physicians by using Advanced Practice Registered Nurses (APRNs) in independent practice, not in physician-led teams, is antithetical to multiple established policies of our AMA and thus should not be implemented; and be it further

RESOLVED, That our AMA staff assess the feasibility of seeking federal legislation that prevents the VA from enacting regulations for veterans' medical care that is not consistent with physician-led health care teams or to mandate that the VA adopt policy regarding the same; and be it further

RESOLVED, That our AMA call upon Congress and the Administration to disapprove or otherwise overturn rules and regulations at the federal level that would expand the scope of practice of Advanced Practice Registered Nurses (APRNs), and comment to the Director of Regulation Management within the Department of Veterans Affairs of this position during the current comment period; and be it further

RESOLVED, That our AMA collaborate with other medical professional organizations to vigorously oppose the final adoption of the VA's proposed rulemaking expanding the role of Advanced Practice Registered Nurses (APRNs) within the VA.

MSS Position: **Support**

MSS Policy Justifying Position: 160.015MSS Physician Extenders; 520.005MSS Ensuring High Quality Care for All Veterans and Their Families; formal support for H-510.985 Access to Health Care for Veterans; formal support for H-510.995 Budgetary and Management Needs of the Veterans Health Administration

Reference Committee C – Medical Education

CME Report 1 – Council on Medical Education Sunset Review of 2006 House Policies

The Council on Medical Education recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

MSS Position: **Support**

MSS Policy Justifying Position: 350.011MSS Continued Support for Diversity in Medical Education; formal support for H-200.951 Strategies for Enhancing Diversity in the Physician Workforce; 255.001MSS The Status of Foreign Medical School Graduates in the United States; 255.003MSS Licensure of International Medical Graduates; 310.020MSS Restrictive Covenants in Training Programs; 295.078MSS Teaching Domestic Violence Screening; 295.079MSS Education of Medical Students About Domestic Violence Histories; Preserving Our Investment in the Face of Medical School Class Size Reductions; 305.052MSS Reduction in Student Loan Interest Rates; 310.034MSS Compensation for Resident/Fellow Physicians; 310.033MSS Eliminating Religious Discrimination from Residency Programs; 295.162MSS Transparency

in the NRMP Match Agreement; 140.027MSS Standardization of Medical Ethics Core Competencies for Undergraduate Medical Education; 385.002MSS The Patient-Centered Medical Home Concept; 295.139 MSS Standardization of Medical Student Background Checks; 295.126MSS Medical Student Clinical Training and Education Conditions; 295.135MSS Increasing Awareness of the Benefits and Risks Associated with Complementary and Alternative Medicine

CME Report 3 – Addressing the Increasing Number of Unmatched Medical Students

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

1. That our AMA reaffirm D-305.967 (4) and (22), The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education: “4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation” and “22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.”

2. That our AMA reaffirm Policy H-200.954 (4) (5) (6) (7), US Physician Shortage: “Our AMA: . . . (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations; (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations; (6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations; (7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas.”

3. That our AMA reaffirm D-310.977 (11), National Resident Matching Program Reform: “Our AMA: . . . (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs.”

MSS Position: **Support**

MSS Policy Justifying Position: 295.069MSS Fairness in the National Resident Matching Program; 295.161MSS Transition from “Scramble” to Supplemental Offer and Acceptance Program; 310.003MSS MSS Graduate Medical Education Financing; formal support for D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education; formal support for D-200.982 Diversity in

the Physician Workforce and Access to Care; formal support for H-350.970 Diversity in Medical Education

CME Report 4 – Resident and Fellow Compensation and Health Care System Value

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 328-A-15 and Resolution 321-A-15 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy H-305.988, which states that our AMA (10) supports AMA monitoring of trends that may lead to a reduction in stipends paid to resident physicians; (12) will advocate that resident and fellow trainees should not be financially responsible for their training.

2. That our AMA modify Policy H-310.922 by addition and deletion to read as follows: “Our AMA encourages that residents’ level of training, cost of living, and other factors relevant to appropriate compensation be considered by graduate training programs when establishing salaries for residents. Our AMA encourages teaching institutions to base residents' salaries on the resident's level of training as well as local economic factors, such as housing, transportation, and energy costs, that affect the purchasing power of wages, with appropriate adjustments for changes in cost of living.”

3. That our AMA encourage teaching institutions to provide benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.

4. That our AMA collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

5. That our AMA monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

6. That our AMA continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents’ compensation and lifetime earnings.

MSS Position: **Support**

MSS Policy Justifying Position: 310.003MSS MSS Graduate Medical Education Financing; 310.034MSS Compensation for Resident/Fellow Physicians

CME Report 5 – Accountability and Transparency in Graduate Medical Education Funding

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 327-A-15 and Resolution 329-A-15 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) endorse the following principles of social accountability and promote their application to GME funding:

- a. Adequate and diverse workforce development;
- b. Primary care and specialty practice workforce distribution;
- c. Geographic workforce distribution; and
- d. Service to the local community and the public at large. (New HOD Policy)

2. That our AMA encourage transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.

3. That our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including:

- a. Resident salary and benefits;
- b. Administrative support for graduate medical education;
- c. Salary reimbursement for teaching staff;
- d. Direct educational costs for residents and fellows; and
- e. Institutional overhead.

4. That our AMA reaffirm Policy D-305.967 (8), Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME. (22), Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation; and (23) Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

5. That our AMA reaffirm Policy H-305.988 (12), Our AMA will advocate that resident and fellow trainees should not be financially responsible for their training.

6. That our AMA monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and that our AMA report back to the House of Delegates, as needed, on important changes in the landscape of GME funding.

MSS Position: **Support**

MSS Policy Justifying Position: 310.003MSS MSS Graduate Medical Education Financing; 310.006MSS The Influence of Residency Training on Quality of Patient Care in Teaching Hospitals; 310.034MSS Compensation for Resident/Fellow Physicians; 310.046MSS Investigating Adverse Public Health Outcomes Relating to Chronic GME Funding Shortages; formal support for D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education

301 – Recognizing the Actual Costs of Student Loans

RESOLVED, That our American Medical Association consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates; and be it further

RESOLVED, That our AMA amend Policy D-305.984 by addition to include Grad-PLUS loans, as follows:

Reduction in Student Loan Interest Rates D-305.984

1. Our American Medical Association will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.

RESOLVED, That our AMA advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden; and be it further

RESOLVED, That our AMA ask the Association of American Medical Colleges to collect data and report student indebtedness that includes total loan costs at time of graduation.

MSS Position: **Support**

MSS Policy Justifying Position: 305.052MSS Reduction in Student Loan Interest Rates; 305.076MSS Collaborative Effort to Reduce Federal Loan Interest Rates; 305.037MSS Medical School Tuition; 305.053MSS Expanding and Strengthening AMA Advocacy on Medical Student Debt; 305.073MSS Transparency in Medical Student Financial Aid Reporting; 305.001MSS Medical Student Loan Program; 305.007MSS Federal Guidelines for Loan Parameters; formal support for D-305.975 Long-Term Solutions to Medical Student Debt; formal support for H-305.928 Proposed Revisions to AMA Policy on Medical Student Debt; formal support for D-305.993 Medical School Financing, Tuition, and Student Debt

302 – Reform and Expand Graduate Medical Education Funding

RESOLVED, That our American Medical Association advocate to reform the current graduate medical education financing system to include an increased allocation of targeted funding directly to primary care residency positions; and be it further

RESOLVED, That our AMA develop recommendations that would assist state medical associations in seeking new state options for alternative funding sources directed to ambulatory-based residency training focused on increasing the primary care physician workforce.

MSS Position: **Oppose Resolved 1, support Resolved 2**

MSS Policy Justifying Position: 310.003MSS MSS Graduate Medical Education Financing; 200.003MSS AMA Opposition to Primary Care Quotas; formal support for H-200.973 Increasing the Availability of Primary Care Physicians; formal support for H-200.997 Primary Care

303 – Research and Monitoring to Ensure Ethics of Global Health Programs

RESOLVED, That our American Medical Association amend Policy H-250.993 by addition to read as follows:

H-250.993 Overseas Medical Education Developed by US Medical Associations

The AMA will: (1) continue to focus its international activities on and through organizations that are multinational in scope; (2) encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world; (3) encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world; (4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities; (5) work with the AAMC to ensure that international electives provide measureable and safe educational experiences for medical students, including appropriate learning objectives and assessment methods; and (6) communicate support for a coordinated approach to global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLO™), to increase student participation in international electives.

MSS Position: **Support**

MSS Policy Justifying Position: 250.026MSS Research and Monitoring to Ensure Ethics of Global Health Programs (HOD resolution is MSS-authored)

304 – Evaluation of Factors During Residency and Fellowship that Impact Routine Health Maintenance

RESOLVED, That our American Medical Association study ways to improve access and reduce barriers to seeking preventive and routine physical and mental health care for trainees in graduate medical education programs.

MSS Position: **Support**

MSS Policy Justifying Position: 140.031MSS Accommodations for Treatment of Medical Students and Residents; 295.164MSS Medical Student Access to Comprehensive Mental Health and Substance Abuse

Treatment; 295.137MSS Expansion of Student Health Services; 310.006MSS The Influence of Residency Training on Quality of Patient Care in Teaching Hospitals; 310.027MSS Resident Work Hours; 310.031MSS Resident/Fellow Work and Learning Environment; formal support for H-295.872 Expansion of Student Health Services

307 – Diversity of the Health Care Workforce to Reduce Disparities

RESOLVED, That our American Medical Association work to support the creation of initiatives for a diverse physician workforce which includes, race, ethnicity, gender, sexual orientation, socioeconomic origins, medical schools attended (either abroad or outside USA) and persons with disabilities.

MSS Position: **Support with deletion of “medical schools attended”**

MSS Policy Justifying Position: 350.011MSS Continued Support for Diversity in Medical Education; 255.001MSS The Status of Foreign Medical School Graduates in the United States; 350.001MSS Minority and Disadvantaged Medical Student Recruitment and Retention Programs; 350.003MSS Minority Representation in the Medical Profession; 350.004MSS Funding for Affirmative Action Programs; 350.005MSS The Disadvantaged Minority Health Improvement Act of 1989; 350.014MSS Youth Health Pipeline Programs Initiative; formal support for D-200.982 Diversity in the Physician Workforce and Access to Care; formal support for D-200.985 Strategies for Enhancing Diversity in the Physician Workforce; formal support for H-200.951 Strategies for Enhancing Diversity in the Physician Workforce; formal support for H-350.978 Minorities in the Health Professions

310 – Standardizing the Allopathic Residency Match System and Timeline

RESOLVED, That our American Medical Association support the movement toward a single United States residency match system and notification timeline for all non-military allopathic specialties; and be it further

RESOLVED, That our AMA work with the Association of University Professors in Ophthalmology, American Academy of Ophthalmology, the Society of University Urologists, the American Urological Association, and any other appropriate stakeholders to switch ophthalmology and urology to the National Resident Matching Program.

MSS Position: **Support**

MSS Policy Justifying Position: **Caucus vote taken to support (2/3)**; 310.051MSS Standardizing the Residency Match System and Timeline; 295.069MSS Fairness in the National Resident Matching Program; 295.136MSS Combining the AOA and ACGME Resident Matching Programs; 310.032MSS National Resident Matching Program

311 – Transfer of Jurisdiction over Required Clinical Skills Examinations to LCME-Accredited and COCA-Accredited Medical Schools

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards and state medical licensing boards to advocate for the elimination of the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) exam and the COMLEX Level 2-PE (Performance Evaluation) as a requirement for Liaison Committee on Medical Education-accredited and Commission on Osteopathic College Accreditation-accredited medical school graduates who have passed a school-administered, clinical skills examination; and be it further

RESOLVED, That our American Medical Association amend AMA Policy D-295.998 by addition to read as follows:

Required Clinical Skills Assessment During Medical School D-295.988

Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to 1) determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills, and 2) require that medical students attending LCME-accredited or American Osteopathic Association Commission on Osteopathic College Accreditation (COCA)-accredited institutions pass a school-administered clinical skills examination to graduate from medical school.

MSS Position: **Support**

MSS Policy Justifying Position: 275.011MSS Transfer of Jurisdiction Over Required Clinical Skills Examination to LCME-Accredited and COCA-Accredited Medical Schools; 295.174MSS Evaluation of Standardized Clinical Skills Exams; 295.150MSS USMLE Exam Fee Burden; 295.117MSS Additions to United States Medical Licensure Examination and College of Osteopathic Medical Licensure Exam; 295.111MSS State Society and State Medical Board Support to Delay Implementation of the USMLE Clinical Skills Assessment Exam; 295.113MSS Clinical Skills Assessment as Part of Medical School Standards; 295.114MSS Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam Implementation

314 – Addiction Medicine as a Multi-Specialty Subspecialty

RESOLVED, That our American Medical Association commend the American Board of Preventive Medicine (ABPM) for its successful application to the American Board of Medical Specialties (ABMS) to establish the new ABMS-approved multispecialty subspecialty of addiction medicine, which will be able to offer certification to qualified physicians who are diplomates of any of the 24 ABMS member boards; and be it further

RESOLVED, That our AMA encourage the ABPM to offer the first ABMS-approved certification examination in addiction medicine in the year 2017 in order to improve access to care to treat addiction.

MSS Position: **Support**

MSS Policy Justifying Position: 95.005MSS Recognition of Addiction as Pathology, Not Criminality; 100.007MSS Naloxone Administration and Heroin Overdose

316 – Transfer of Jurisdiction Over Required Clinical Skills Examinations to LCME-Accredited and COCA-Accredited Medical Schools

RESOLVED, That our American Medical Association, working with the state medical societies, advocate for the Federation of State Medical Boards (FSMB) and state medical boards to eliminate the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and the Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) as a requirement for Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school graduates who have passed a school-administered, clinical skills examination; and be it further

RESOLVED, That our AMA advocate for medical schools and medical licensure stakeholders to create standardizing a clinical skills examination that would be administered at each Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school in lieu of United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) and that would be a substitute prerequisite for future licensure exams; and be it further

RESOLVED, That our AMA amend Policy D-295.998 by addition and deletion to read as follows:

Required Clinical Skills Assessment During Medical School D-295.998

Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to 1) determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills, and 2) require that medical students attending LCME-accredited institutions pass a school-administered, clinical skills examination to graduate from medical school.

MSS Position: **Support**

MSS Policy Justifying Position: 275.011MSS Transfer of Jurisdiction Over Required Clinical Skills Examination to LCME-Accredited and COCA-Accredited Medical Schools; 295.174MSS Evaluation of Standardized Clinical Skills Exams; 295.150MSS USMLE Exam Fee Burden; 295.117MSS Additions to United States Medical Licensure Examination and College of Osteopathic Medical Licensure Exam; 295.111MSS State Society and State Medical Board Support to Delay Implementation of the USMLE Clinical Skills Assessment Exam; 295.113MSS Clinical Skills Assessment as Part of Medical School Standards; 295.114MSS Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam Implementation

317 – Transfer of Jurisdiction Over Required Clinical Skills Examinations to U.S. Medical Schools

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards and state medical licensing boards to advocate for the elimination of the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) exam as a requirement for Liaison Committee

on Medical Education-accredited graduates who have passed a school-administered, clinical skills examination; and be it further

RESOLVED, That our AMA amend Policy D-295.998 by addition and deletion to read as follows:

Required Clinical Skills Assessment During Medical School D-295.998

Our AMA will advocate that encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME, to 1) determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should “develop a system of assessment” to assure that students have acquired and can demonstrate core clinical skills, and 2) require that medical students attending LCME-accredited institutions pass a school-administered clinical skills examination to graduate from medical school.

MSS Position: **Support**

MSS Policy Justifying Position: 275.011MSS Transfer of Jurisdiction Over Required Clinical Skills Examination to LCME-Accredited and COCA-Accredited Medical Schools; 295.174MSS Evaluation of Standardized Clinical Skills Exams; 295.150MSS USMLE Exam Fee Burden; 295.117MSS Additions to United States Medical Licensure Examination and College of Osteopathic Medical Licensure Exam; 295.111MSS State Society and State Medical Board Support to Delay Implementation of the USMLE Clinical Skills Assessment Exam; 295.113MSS Clinical Skills Assessment as Part of Medical School Standards; 295.114MSS Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam Implementation

319 – Specialty-Specific Allocation of GME Funding

RESOLVED, that our AMA support specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

MSS Position: **Support**

MSS Policy Justifying Position: 310.003MSS MSS Graduate Medical Education Financing; 310.034MSS Compensation for Resident/Fellow Physicians; 310.046MSS Investigating Adverse Public Health Outcomes Relating to Chronic GME Funding Shortages; formal support for H-305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs; formal support for H-310.917 Securing Funding for Graduate Medical Education; formal support for D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education

321 – Transfer of Jurisdiction Over Required Clinical Skills Examination to LCME-Accredited and COCA-Accredited Medical Schools

RESOLVED, That our AMA, working with the state medical societies, advocate for the Federation of State Medical Boards (FSMB) and state medical boards to eliminate of the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and the Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) as a requirement for Liaison Committee

on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school graduates who have passed a school-administered, clinical skills examination; and be it further

RESOLVED, That our AMA to amend D-295.998 by insertion and deletion as follows:

Required Clinical Skills Assessment During Medical School D-295.998

Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to 1) determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills, and 2) require that medical students attending LCME-accredited institutions pass a school-administered clinical skills examination to graduate from medical school.

RESOLVED, That our AMA advocate for medical schools and medical licensure stakeholders to create guidelines standardizing the clinical skills examination that would be administered at each LCME-accredited and COCA-accredited medical school in lieu of USMLE Step 2 CS and COMLEX Level 2-PE and would be a substitute prerequisite for future licensure exams.

MSS Position: **Support**

MSS Policy Justifying Position: 275.011MSS Transfer of Jurisdiction Over Required Clinical Skills Examination to LCME-Accredited and COCA-Accredited Medical Schools (HOD resolution is MSS-authored)

Reference Committee D – Public Health

CSAPH Report 4 – Powdered Alcohol

The Council on Science and Public Health recommends that the following recommendation be adopted, and the remainder of the report be filed.

That our American Medical Association supports federal and state laws banning the manufacture, importation, distribution, and sale of powdered or crystalline alcohol intended for human consumption.

MSS Position: **Oppose**

MSS Policy Justifying Position: **Caucus vote taken to oppose (2/3)**

CSAPH Report 6 - Delaying School Start Time to Alleviate Adolescent Sleep Deprivation

The Council on Science and Public Health recommends that the following statements be adopted in lieu of Res 404-A-15 and the remainder of the report be filed.

That our American Medical Association:

1. Encourage school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep.
2. Encourage physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents.
3. Reaffirm Policy H-60.930, Insufficient Sleep in Adolescents, identifying adolescent insufficient sleep and sleepiness as a public health issue and supporting education about sleep health as a standard component of care for adolescent patients.
4. Encourage continued research on the impact of sleep on adolescent health and academic performance.

MSS Position: **Support**

MSS Policy Justifying Position: 60.022MSS Altering School Days to Alleviate Adolescent Sleep Deprivation; 440.021MSS Promoting Fitness and Healthy Lifestyles;

CSAPH Report 7 - Preventing Violent Acts Against Health Care Providers

The Council on Science and Public Health recommends that the following recommendations be adopted, and the remainder of the report be filed.

That our AMA:

1. Encourage the Occupational Safety and Health Administration to develop and enforce a standard addressing workplace violence prevention in health care and social service industries.
2. Encourage Congress to provide additional funding to the National Institute for Occupational Safety and Health to further evaluate programs and policies to prevent violence against health care workers.
3. Encourage the National Institute for Occupational Safety and Health to adapt the content of their online continuing education course on workplace violence for nurses into a continuing medical education course for physicians.
4. Amend Policy H-515.966, "Violence and Abuse Prevention in the Health care Workplace," by addition and deletion to read as follows:

Our AMA encourages all health care facilities to: adopt policies to reduce and prevent all forms of workplace violence and abuse; develop a reporting tool that is easy for workers to find and complete; and develop policies to assess and manage reported occurrences of workplace violence and abuse; and will advocate that make training courses on workplace violence prevention available to employees and consultants and reduction be more widely available; and include physicians in safety and health committees.

5. Amend Policy H-215.978, "Guns in Hospitals," by addition and deletion and a change in title to better reflect the content of the policy to read as follows:

Workplace Violence Prevention

Our AMA: (1) supports the efforts of the International Association for Healthcare Security and Safety, the AHA, and The Joint Commission to develop guidelines or standards regarding hospital security issues and recognizes these groups' collective expertise in this area. As standards are developed, the AMA will ensure that physicians are advised; (2) encourages physicians to work with their hospital safety committees to address the security issues within particular hospitals; ~~and also encourages physicians to become aware of and familiar with their own institution's policies and procedures; and encourages physicians to participate in training to prevent and respond to workplace violence threats; encourages physicians to report all incidents of workplace violence; and encourages physicians to promote a culture of safety within their workplace.~~ and (3) urges that hospital safety committees include physicians and that emergency departments be recognized as high risk environments for violence.

6. Amend Policy D-515.983, "Preventing Violent Acts Against Healthcare Providers," by addition and deletion to read as follows (as it has been implemented in part):

~~1. Our AMA will make CSAPH Report 2-I-10, Violence in the Emergency Department, available to hospitals, emergency medicine departments, emergency physicians, mental health physicians, patient advocates, and law enforcement organizations as a resource designed to assist in the implementation of procedures to protect students, trainees, physicians, nurses, and other health care staff in the Emergency Department environment and to assure optimal care for patients, including those with psychiatric or behavioral conditions. 2. Our American Medical Association will: (a) continue to work with other appropriate organizations to study mechanisms to prevent acts of violence against health care providers and improve the safety and security of providers while engaged in caring for patients; and (b) widely disseminate information on effective workplace violence prevention interventions in the health care setting as well as opportunities for training the results of this study.~~

MSS Position: **Support**

MSS Policy Justifying Position: 515.002MSS Physicians and Other Health Care Personnel as Targets of Threats, Harassment, and Violence; formal support for H-515.979 Violence as a Public Health Issue

CSAPH Report 8 - Juvenile Justice System Reform

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 205-I-14, and the remainder of the report be filed.

That our American Medical Association:

1. Reaffirm policies H-60.922, "Solitary Confinement of Juveniles in Legal Custody," D-430.997, "Support for Health Care Services to Incarcerated Persons," and H-60.986, "Health Status of Detained and Incarcerated Youth."

2. Support school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than “zero tolerance” policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
3. Encourage continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
4. Encourage states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
5. Support reforming laws and policies to reduce the number of youth transferred to adult criminal court.
6. Support the reauthorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (1) community-based alternatives for youth who pose little risk to public safety, (2) reentry and aftercare services to prevent recidivism, (3) policies that promote fairness to reduce disparities, and (4) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.
7. Encourage juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
8. Encourage states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.
9. Encourage Congress to enact legislation prohibiting evictions from public housing based solely on an individual’s relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile’s rehabilitation efforts.

MSS Position: **Support**

MSS Policy Justifying Position: 270.029MSS AMA Support for Justice Reinvestment Initiatives; 65.007MSS Gender-Specific Rehabilitative Programs, Mental Health, and Educational Services for Girls in the Juvenile Detention System; 60.023MSS Legal Protection and Social Services for Commercially Sexually Exploited Youth; 140.028MSS Solitary Confinement; 345.008MSS Improving the Intersection Between Law Enforcement and the Mentally Ill

401 - Evidence-Based Sexual Education Enforcement in School

RESOLVED, That our American Medical Association encourage 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.

MSS Position: **Support**

MSS Policy Justifying Position: 170.010MSS Abstinence-Only Education and Federally-Funded Community-Based Initiatives; 170.004MSS Health Education; 170.006MSS Sexual Violence Education and Prevention in High Schools with Sexual Health Curricula; 75.008MSS Opposition to Sole Funding of Abstinence-Only Education; 170.005MSS Teaching Sexual Restraint to Adolescents; formal support for H-170.968 Sexuality Education, Abstinence, and Distribution of Condoms in Schools

402 - Addressing Sexual Assault on College Campuses

RESOLVED, That our American Medical Association support 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.

MSS Position: **Support**

MSS Policy Justifying Position: 515.009MSS Addressing Sexual Assault on College Campuses (HOD resolution is MSS-authored)

403 - Policies on Intimacy and Sexual Behavior in Residential Aged-Care Facilities

RESOLVED, That our American Medical Association urge long-term care facilities and other appropriate organizations to adopt policies and procedures on intimacy and sexual behavior that preserve residents' rights to pursue sexual relationships, while protecting them from unsafe, unwanted, or abusive situations; and be it further

RESOLVED, That our AMA urge long-term care facilities and other appropriate organizations to provide staff with in-service training to develop a framework to address intimacy in their patient population.

MSS Position: **Support**

MSS Policy Justifying Position: 65.020MSS Policies on Intimacy and Sexual Behavior in Residential Aged Care Facilities (HOD resolution is MSS-authored)

405 - Sexual Violence Education and Prevention in Schools

RESOLVED, That our AMA amend Policy H-170.968 by addition and deletion to read as follows:

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

Our AMA:(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; ~~(b)~~ (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; ~~(e)~~ (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; ~~(d)~~ (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; ~~(e)~~ (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and ~~(f)~~ (g) are part of an overall health education program; (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, 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; (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; and (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, conversations about consent.

MSS Position: **Support**

MSS Policy Justifying Position: 170.016MSS Sexual Violence Education and Prevention in High Schools with Sexual Health Curricula (HOD resolution is MSS-authored)

406 - Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes

RESOLVED, That our American Medical Association study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.

MSS Position: **Support**

MSS Policy Justifying Position: 440.054MSS Increase Advocacy and Research into the Effects of Police Brutality on Public Health Outcomes (HOD resolution is MSS-authored)

407 - Tobacco Products in Pharmacies and Healthcare Facilities

RESOLVED, That our American Medical Association support the position that the sale of any 10 tobacco or vaporized nicotine products be prohibited where healthcare is delivered or where 11 prescriptions are filled.

MSS Position: **Support with amendment to exclude smoking cessation products**

MSS Policy Justifying Position: 505.011MSS Opposing the Sale of Tobacco in Retail and Grocery Stores

409 – Lead and Copper Rule Compliance

RESOLVED, That our American Medical Association work with the Environmental Protection Agency (EPA) to shorten and streamline the Lead and Copper Rule compliance deadline requirements in the Safe Drinking Water Act with the goal of avoiding unnecessary multi-year periods and other prolonged compliance deadlines, while maintaining reasonableness in review of circumstances on a case-by-case basis.

MSS Position: **Support**

MSS Policy Justifying Position: 440.057MSS Improving Detection, Awareness, and Prevention of Lead Contamination in Water; 135.002MSS Environmental Protection; 170.001MSS Prevention & Health Education

410 – Baby-Friendly Health Care Delivery and Breastfeeding Rights

RESOLVED, That our American Medical Association adopt policy that supports the implementation of the full ten steps of the World Health Organization (WHO) Baby-Friendly Hospital Initiative in all sites of health care delivery; and be it further

RESOLVED, That our AMA adopt policy supporting the evaluation and grading of the practice of breastfeeding as an intervention, as developed by the United States Preventive Services Task Force (USPSTF).

MSS Position: **Support Resolved 2**

MSS Policy Justifying Position: 245.002MSS AMA Support for Breastfeeding; 245.011MSS Protecting a Mother's Right to Breastfeed; 245.016MSS Doctors Defending Breastfeeding; 245.013MSS Promoting Breastfeeding in Hospitals; 270.017MSS Support for Legislation for Businesses to Provide Breastfeeding Employees Time, Facilities and Equipment for Breastfeeding; formal support for H-245.982 AMA Support for Breastfeeding

412 – Ban Electronic Cigarette Advertisement

RESOLVED, That our American Medical Association, consistent with AMA Policy H-495.973, advocate by any means necessary for a total ban of electronic cigarette advertising on television and radio.

MSS Position: **Support**

MSS Policy Justifying Position: 500.005MSS International Ban on Tobacco Advertising; 500.003MSS Tobacco Advertising Tax Deduction; 500.006MSS Restricting the Sale of E-Cigarettes to Minors; formal support for H-495.985 Smokeless Tobacco; formal support for H-495.987 Tobacco Taxes

413 – Ban Lead in Plumbing

RESOLVED, That our American Medical Association pursue lead-free standards at the federal level that are actually lead-free, for all plumbing related to drinking water.

MSS Position: **Support**

MSS Policy Justifying Position: 440.057MSS Improving Detection, Awareness, and Prevention of Lead Contamination in Water; 135.002MSS Environmental Protection; 170.001MSS Prevention & Health Education

414 – Replace Municipal Lead Plumbing

RESOLVED, That our American Medical Association strongly advocate that the United States of America end the man-made scourge of lead in drinking water by taking swift action to support the replacement of lead plumbing throughout our country.

MSS Position: **Support**

MSS Policy Justifying Position: 440.057MSS Improving Detection, Awareness, and Prevention of Lead Contamination in Water; 135.002MSS Environmental Protection; 170.001MSS Prevention & Health Education

415 – Regular Monitoring of Water at School and Daycare Sites

RESOLVED, That our American Medical Association lobby at the federal level for the following mandates: 1) that all schools and registered daycare sites be among those sites routinely chosen by municipal water quality assurance testing as part of the Safe Drinking Water Act enforcement; and 2) in cases where there are abnormal test results from water testing at schools and registered daycare sites, that those sites continue to be tested repeatedly until results return to normal.

MSS Position: **Support**

MSS Policy Justifying Position: 440.057MSS Improving Detection, Awareness, and Prevention of Lead Contamination in Water; 135.002MSS Environmental Protection; 170.001MSS Prevention & Health Education

416 – Timely and Transparent Data Sharing for Drinking Water Testing

RESOLVED, That our American Medical Association lobby at the federal level for legislation, regulations, and/or policies that would do the following:

1. Require all municipal water test results performed by municipal, city, county, district or state agencies to be posted on a publicly available website within seven business days of their receipt.
2. Require all communicable disease reports performed by city, county, district or state agencies to be posted on a publicly available website within seven business days of their receipt.
3. Require reports of sewage overflows to be posted on a publicly available website within four hours of the receipt of such reports.
4. Create and make available a real-time alert system for all water test results, which exceed federal, state, or local standards within a person's designated zip code(s), to which the public could subscribe.
5. Create and make available a process in which all collected test results related to the quality of water that are excluded from final data analysis are annotated and explained.

MSS Position: **Support**

MSS Policy Justifying Position: 440.057MSS Improving Detection, Awareness, and Prevention of Lead Contamination in Water; 135.002MSS Environmental Protection; 170.001MSS Prevention & Health Education

417 – Changing Public Policy to Assist Obesity Goals

RESOLVED, That our American Medical Association support efforts to limit the consumption of foods and beverages that contain added sweeteners, including but not limited to, ending corn subsidies for the production of high fructose corn syrup.

MSS Position: **Support**

MSS Policy Justifying Position: 150.020MSS Decreasing Incidence of Obesity and Negative Sequelae by Reducing the Cost Disparity Between Calorie-Dense, Nutrition Poor Foods and Nutrition-Dense Foods; 150.022MSS Support for Fees and Taxes on Non-Alcoholic Beverages Containing Caloric Sweeteners; 440.013MSS Obesity as a Chronic Disease; 440.018MSS Childhood Obesity as a Public Health Epidemic; formal support for H-440.902 Obesity as a Major Health Concern; formal support for D-440.971 Recommendations for Physician and Community Collaboration on the Management of Obesity; formal support for H-150.953 Obesity as a Major Public Health Program; formal support for H-150.944 Combating Obesity and Health Disparities

422 – Sunscreen Use at Schools and Summer Camps

RESOLVED, That our American Medical Association develop an educational campaign focused on the importance of reducing mid-day sun exposure and of using sunscreen and sun protective clothing for children at school and summer camp programs, with report back at the 2016 Interim Meeting; and be it further

RESOLVED, That our AMA work with state and specialty medical societies and patient advocacy groups to provide advocacy resources and model legislation for use in state advocacy campaigns seeking the removal of sunscreen-related bans at schools and summer camp programs.

MSS Position: **Support**

MSS Policy Justifying Position: 440.042MSS Permitting Sunscreen in Schools; 440.044MSS Sunscreen and Sun Protection Counseling by Physicians; 60.011MSS Sun Protection Programs in Elementary Schools; formal support for D-170.997 Sun Protection Programs in Elementary Schools

423 – Core Measure for Flu Vaccination

RESOLVED, That our American Medical Association study the benefits and risks of systematically administering flu vaccinations to post-operative patients in the hospital setting, with report back at the 2016 Interim Meeting.

MSS Position: **Support**

MSS Policy Justifying Position: 440.002MSS Immunization Programs for Children; 440.051MSS A Comprehensive Education Strategy to Improve Vaccination Rates; formal support for H-440.970 Religious Exemptions from Immunizations

424 – Enhanced Zika Virus Public Health Action – NOW

RESOLVED, That our AMA immediately increase its advocacy efforts for adequate Federal and state support for Zika virus control and research--including vector and pathogenesis research, vaccine development, environmental and vector controls, targeted Zika testing and treatment, patient education, public education, and the notification and education of those who may have been exposed to Zika viruses sexually or by mosquitoes; and be it further

RESOLVED, That our AMA work with experts in all relevant disciplines, and convene expert workgroups when appropriate, to help develop needed American and global strategies and limit the spread and impact of this virus; and be it further

RESOLVED, That our AMA consider collaboration with other educational and promotional entities (e.g., the AMA Alliance) to develop and promote family-directed and community-directed strategies that minimize the transmission of Zika virus to potentially pregnant women.

MSS Position: **Support**

MSS Policy Justifying Position: 440.046MSS Prevention of Mosquito Transmitted Diseases; 250.011MSS Low Cost Drugs to Poor Countries During Times of Pandemic Health Crisis; Medical Student Involvement in Disaster Medicine and Public Health Preparedness Planning and Response; 440.002MSS Immunization Programs for Children

425 – Oppose Efforts to Stop, Weaken or Delay FDA's Authority to Regulate All Tobacco Products

RESOLVED, That our American Medical Association oppose any legislation that would stop, weaken or delay FDA's authority to fully regulate all tobacco products.

MSS Position: **Support**

MSS Policy Justifying Position: 490.008MSS Regulation of Tobacco Products by the Food and Drug Administration; 490.023MSS Revising AMA Policy to Better Define "Tobacco Products"; 500.006MSS Restricting the Sale of E-Cigarettes to Minors; formal support for H-495.988 FDA Regulation of Tobacco Products

426 – Weapons, Hospital Workplace and Patient Safety Issues

RESOLVED, That our American Medical Association advocate that hospitals and other healthcare delivery settings restrict guns and Tasers on their premises, particularly in emergency departments and psychiatric units where patients suffering from mental illness are present; and be it further

RESOLVED, That our AMA reaffirm Policy 145.975 and support Joint Commission's position which strongly encourages its accredited institutions to report "sentinel events"⁹ defined as patient safety events that result in "death, permanent harm, or severe temporary harm and intervention necessary to sustain life"; and be it further

RESOLVED, That our AMA encourage all hospitals to invest in comprehensive training of security personnel that focus on patient safety, empathy, and de-escalation; and be it further

RESOLVED, That our AMA advocate for increased resources and broader efforts to work with partner organizations, such as the National Alliance on Mental Health, to increase awareness, access, and education to de-stigmatize mental health among minority communities.

MSS Position: **Support**

MSS Policy Justifying Position: 365.004MSS Hospital Workplace and Patient Safety and Weapons; 345.008MSS Improving the Intersection Between Law Enforcement and the Mentally Ill; 440.054MSS Increase Advocacy and Research into the Effects of Police Brutality on Public Health Outcomes; formal support for H-145.997 Firearms as a Public Health Problem in the United States - Injuries and Death; 515.002MSS Physicians and Other Health Care Personnel as Targets of Threats, Harassment, and Violence

428 – Lead Contamination in Flint Water: Negligence

RESOLVED, That our American Medical Association advocate for hematological and neurodevelopmental monitoring at established intervals for the children of Flint who are exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure; and be it further

RESOLVED, That our AMA urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL; and be it further

RESOLVED, That our AMA advocate for appropriate nutritional support for all Flint residents, but especially exposed pregnant women, lactating mothers and exposed children. That support should include Vitamin C, green leafy vegetables and other calcium sources so that their bodies will not be forced to substitute lead for missing calcium as the children grow; and be it further

RESOLVED, That our AMA promote screening, diagnosis and treatment of lead exposure and iron deficiency anemia in all Flint residents, especially women and children.

MSS Position: **Support Resolveds 1, 2, and 4; oppose Resolved 3**

MSS Policy Justifying Position: 440.057MSS Improving Detection, Awareness, and Prevention of Lead Contamination in Water; 135.002MSS Environmental Protection; 170.001MSS Prevention & Health Education

429 – Appropriate Labeling of Sleep Products for Infants

RESOLVED, That our American Medical Association adopt the following excerpted guidelines of the Safe Infant Sleeping Environment Guidelines adapted from the American Academy of Pediatrics and the Centers for Disease Control and Prevention (CDC), which read as follows:

- Avoid commercial devices marketed to reduce the risk of SIDS. These devices include wedges, positioners, special mattresses, and special sleep surfaces. There is no evidence that these devices reduce the risk of SIDS or suffocation or that they are safe.

- Media and manufacturers should follow safe-sleep guidelines in their messaging and advertising; and be it further

RESOLVED, That our AMA advocate for the appropriate labeling of all infant sleep products that are not in compliance with the American Academy of Pediatrics and the CDC “Safe Infant Sleeping Environment Guidelines” to adequately warn consumers of the risks of product use.

- Media and manufacturers should follow safe-sleep guidelines in their messaging and advertising; and be it further

RESOLVED, That our AMA advocate on the state and federal level for the appropriate labeling of all infant sleep products that are not in compliance with the American Academy of Pediatrics and the CDC “Safe Infant Sleeping Environment Guidelines” to adequately warn consumers of the risks of product use.

MSS Position: **Support**

MSS Policy Justifying Position: 245.003MSS Sudden Infant Death Syndrome; 10.003MSS Mandatory Labeling for Waterbeds and Beanbag Furniture

431 – Funding for Zika Control and Research

RESOLVED, That our American Medical Association urge Congress to enact legislation, without further delay, to provide increased and sufficient funding for research, prevention, control, and treatment of illnesses associated with the Zika virus commensurate with the public health emergency that the virus poses without diverting resources from other essential health initiatives.

MSS Position: **Support**

MSS Policy Justifying Position: 440.046MSS Prevention of Mosquito Transmitted Diseases; 250.011MSS Low Cost Drugs to Poor Countries During Times of Pandemic Health Crisis; Medical Student Involvement in Disaster Medicine and Public Health Preparedness Planning and Response; 460.009MSS Support for Increase in Federal Funding for the National Institutes of Health

Reference Committee E – Science and Technology

CSAPH Report 2 – Human and Environmental Effects of Light Emitting Diode (LED) Community Lighting

The Council on Science and Public Health recommends that the following statements be adopted, and the remainder of the report filed.

1. That our American Medical Association (AMA) support the proper conversion to community-based Light Emitting Diode (LED) lighting, which reduces energy consumption and decreases the use of fossil fuels.
2. That our AMA encourage minimizing and controlling blue-rich environmental lighting by using the lowest emission of blue light possible to reduce glare.
3. That our AMA encourage the use of 3000K or lower lighting for outdoor installations such as roadways. All LED lighting should be properly shielded to minimize glare and detrimental human and environmental effects, and consideration should be given to utilize the ability of LED lighting to be dimmed for off-peak time periods.

MSS Position: **Support**

MSS Policy Justifying Position: 135.002MSS Environmental Protection; 135.005MSS Promotion of Conservation Practices within the AMA; 135.012MSS Toward Environmental Responsibility; 135.013MSS Statement of Sustainability Principles

CSAPH Report 3 – The Precision Medicine Initiative

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

1. That our American Medical Association work with the Precision Medicine Initiative (PMI) to gather input from physicians to assist in the planning stages of the initiative and to improve awareness and willingness to recruit patients as participants.
2. That our AMA encourage the PMI to develop resources that will assist physicians in understanding the goals of the PMI, how to recruit and enroll patients, and how to best use the research results generated by it.
3. That our AMA continue to advocate for improvements to electronic health record systems that will enable interoperability and access while not creating additional burdens and usability challenges for physicians.

MSS Position: **Support**

MSS Policy Justifying Position: 165.010MSS Development and Support of Prospective Personalized Health Planning; 460.004MSS Human Genome Project; 200.019MSS Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems; 315.003MSS Enabling a Contiguous, National Electronic Health Record Network; formal support for H-460.908 Genomic-Based Personalized Medicine; formal support for D-478.994 Health Information Technology; formal support for D-478.995 National Health Information Technology

CSAPH Report 5 – An Expanded Definition of Women's Health

The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolution 604-A-15 and the remainder of the report be filed.

1. That our American Medical Association (AMA) recognize the term “women’s health” as inclusive of all health conditions for which there is evidence that women’s risks, presentations, and/or responses to treatments are different from those of men, and encourage that evidence-based information regarding the impact of sex and gender be incorporated into practice.
2. That Policy H-525.991, Inclusion of Women in Clinical Trials, be amended by addition to read as follows:
 1. Our AMA encourages the inclusion of women in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike; 2. supports the National Institutes of Health policy requiring investigators to account for the possible role of sex as a biological variable in vertebrate animal and human studies; and 3. encourages translation of important research results into practice.
3. That Policy H-525.988, Sex and Gender Differences in Medical Research, be reaffirmed.

MSS Position: **Support**

MSS Policy Justifying Position: 295.061MSS Support for Women's Health Training; 525.001MSS Inclusion of Women in Clinical Trials

502 – In-Flight Medical Emergencies

RESOLVED, That our American Medical Association work with the Federal Aviation Administration (FAA) and other appropriate organizations to require airlines to provide a list of available in-flight medical supplies in accessible locations; and be it further

RESOLVED, That our AMA work with the FAA and other appropriate organizations to facilitate the creation of a centralized and standardized system to report all medical emergencies requiring assistance from a medically-trained passenger or from ground-based communications; and be it further

RESOLVED, That our AMA work with the FAA and other appropriate organizations to ensure that a routine process exists to verify functionality of medical equipment and medicines used for in-flight medical emergencies.

MSS Position: **Support**

MSS Policy Justifying Position: 150.012MSS Allergic Reactions in Schools and Airplanes; formal support for H-45.981 Improvement in US Airlines Aircraft Emergency Kits; formal support for H-45.979 Air Travel Safety; formal support for H-45.978 In-flight Medical Emergencies

503 – Cost-Effective Technologies as a Solution to Wandering Patients with Alzheimer's Disease and Other Related Dementias

RESOLVED, That our American Medical Association support the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations.

MSS Position: **Support**

MSS Policy Justifying Position: 480.016MSS Implementation of Cost Effective Technologies as a Solution to Wandering Patients with Alzheimer's Disease and Other Related Disorders (HOD resolution is MSS-authored)

504 – Conservation, Recycling and Environmental Stewardship

RESOLVED, That our American Medical Association encourage all health systems to facilitate effective and robust recycling programs with a recommended goal of a 25% rate when feasible; and be it further

RESOLVED, That our AMA encourage all undergraduate and graduate medical education programs to facilitate effective and robust recycling programs when feasible; and be it further

RESOLVED, That our AMA encourage health systems, medical schools, and graduate medical education offices to evaluate their overall environmental impact, create goals for improvement and create a plan and a timeline to meet those goals; and be it further

RESOLVED, That our AMA support resources and incentives that aid and encourage hospital employees and physicians who partake in environmentally conscientious activities (benefits for carpooling or taking the bus, showers at work for biking/jogging to work, etc.).

MSS Position: **Support**

MSS Policy Justifying Position: 135.003MSS Recycling in the Medical Community; 135.006MSS Recycling; 135.013MSS Statement of Sustainability Principles; 135.005MSS Promotion of Conservation Practices within the AMA; 135.002MSS Environmental Protection; 135.012MSS Toward Environmental Responsibility

505 – Radon Testing in Rentals

RESOLVED, That our American Medical Association support transparency and disclosure in prior radon testing, the most recent results of such testing, prior mitigation or remediation efforts, and other relevant information to protect renters and tenants when entering into a lease.

MSS Position: **Support**

MSS Policy Justifying Position: 440.056MSS Radon Testing in Rentals

506 – Heart Disease and Women

RESOLVED, That our American Medical Association and its partner organizations facilitate increased awareness of heart disease in women; and be it further

RESOLVED, That our AMA support education on preventive measures for heart disease in women; and be it further

RESOLVED, That our AMA encourage its members to foster increased comprehensive care of heart disease as it is the number one cause of death in women; and be it further

RESOLVED, That our AMA promote research to address the gaps in knowledge related to coronary pathophysiology, optimal diagnostic testing and imaging, and optimal pharmacologic and interventional strategies; and be it further

RESOLVED, That our AMA encourage additional research to better understand the role of demographic, socioeconomic, and psychological factors in the onset of heart disease in women.

MSS Position: **Support**

MSS Policy Justifying Position: 295.061MSS Support for Women's Health Training; 525.001MSS Inclusion of Women in Clinical Trials

511 – Transparency in Television Advertising of Unregulated Medications and Medical Devices

RESOLVED, That our American Medical Association adopt policy that all non-FDA-approved health care related products advertised on all media that are promoted with respect to health conditions display the following warning: "These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease." This warning must be prominently stated in print or voice throughout the advertisement for consideration by the consumer; and be it further

RESOLVED, That it be American Medical Association policy that all advertisements for health care related products not approved by the FDA include evidence-based information about the risks and benefits of the product.

MSS Position: **Support**

MSS Policy Justifying Position: 105.001MSS Drug Advertising to the Public; 440.024MSS Advertising for Herbal Supplements; 105.002MSS FDA Regulation of OTC Medication Advertising; 75.011MSS Informed Consent with Regards to Advertising and Prescribing Contraceptives; formal support for H-105.988 Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices

513 – Action to Address Illegal Methamphetamine Production

RESOLVED, That our American Medical Association supports: (1) a national ban on over-the-counter sales of pseudoephedrine, ephedrine, phenylpropanolamine, and any other current or future products that are able to be used to produce methamphetamine; and (2) the replacement of over-the-counter products containing pseudoephedrine, ephedrine, phenylpropanolamine, and other like products used to produce methamphetamine with their tamper- or meth-resistant counterparts; and be it further

RESOLVED, That our American Medical Association work with the pharmaceutical and retail industries to encourage the voluntary removal of or requirement for a prescription for non-tamper-resistant pseudoephedrine, ephedrine, phenylpropanolamine, and other like products from businesses that sell such products over-the-counter until such time as a ban on the sale of these products is implemented.

MSS Position: **Support**

MSS Policy Justifying Position: 95.002MSS Methamphetamine Abuse

514 – Opposing Tax Deductions for Direct-to-Consumer Advertising

RESOLVED, That our American Medical Association oppose allowing costs for direct-to-consumer advertising of prescription medications, medical devices, and controlled drugs to be considered deductible business expenses for tax purposes.

MSS Position: **Support**

MSS Policy Justifying Position: 105.003MSS Opposing Tax Deductions for Direct To Consumer Advertising

515 – NPS Report Distribution to Practicing Physicians

RESOLVED, That our American Medical Association distribute and promote the National Pain Strategy report to practicing physicians.

MSS Position: **Support**

MSS Policy Justifying Position: 440.023MSS Support for a National Center on Pain Research; 270.009MSS Protection for Physicians who Prescribe Pain Medication; 100.012MSS Support for the Use of Pain Contracts; formal support for Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985; formal support for H-120.960 Protection for Physicians Who Prescribe Pain Medication

517 – Cardiopulmonary Resuscitation (CPR) in Post-Acute and Long-Term Care

RESOLVED, That our American Medical Association further promulgate information to health care professionals and consumers to promote informed decision-making about Cardiopulmonary Resuscitation (CPR) by patients and their families.

MSS Position: **Support**

MSS Policy Justifying Position: 140.007MSS AMA-MSS Support of Advance Directives; 130.002MSS Use of Automatic External Defibrillators; 245.001MSS Cardiopulmonary Resuscitation Training for Expectant and New Parents; 295.083MSS Cardiopulmonary Resuscitation and Basic Life Support Training for First Year Medical Students; 140.024MSS Encouraging Standardized Advance Directives Forms within States; 140.033MSS Addressing the Importance of Advance Directive Planning and Education for Medical Students; formal support for D-140.976 Advance Health Care Directive; formal support for H-295.906 Cardiopulmonary Resuscitation and Basic Life Support Training for First-Year Medical Students

519 – Support for Hemorrhage Control Training

RESOLVED, That our American Medical Association encourage state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control; and be it further

RESOLVED, That our AMA encourage, through state medical and specialty societies, the provision of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for law enforcement, fire, rescue and emergency medical personnel; and be it further

RESOLVED, That our AMA advocate for the inclusion of hemorrhage control supplies (including pressure bandages, hemostatic dressings and tourniquets) on all commercial aircraft.

MSS Position: **Support**

MSS Policy Justifying Position: 145.001MSS Handgun Violence; 460.019MSS Removing Restrictions on Federal Funding for Firearm Research; formal support for H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care; formal support for H-

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

520 – Medical Marijuana Use in Women of Reproductive Age

RESOLVED, That our American Medical Association adopt the American College of Obstetrics and Gynecology Committee on Obstetric Practice's policies on marijuana use during pregnancy and lactation, as follows:

1. Before and during pregnancy, all women should be asked about their use of tobacco, alcohol, other drugs (including marijuana), and medications used for nonmedical reasons.
2. Women reporting marijuana use should be counseled about concerns regarding potential adverse health consequences of use during pregnancy.
3. Women who are pregnant or contemplating pregnancy should be encouraged to avoid marijuana use.
4. Pregnant women or women contemplating pregnancy should be encouraged to avoid use of marijuana for medicinal purposes in favor of an alternative therapy for which there are better pregnancy-specific safety data.
5. There are insufficient data to evaluate the effects of marijuana use on infants during lactation and breastfeeding, and in the absence of such data, marijuana use is discouraged; and be it further

RESOLVED, That our AMA encourage continuing medical education for licensed physicians who certify patients to use medicinal marijuana, include training about the risks of marijuana on reproduction, pregnancy, and breastfeeding; and be it further

RESOLVED, That our AMA encourage physicians who certify patients to use medicinal marijuana counsel women and men of reproductive age on the risks that marijuana use has on reproduction, pregnancy, and breastfeeding; and be it further

RESOLVED, That our AMA encourage physicians who certify female patients to receive marijuana for medical use to assess their patients' pregnancy status and contraceptive method at each visit; and be it further

RESOLVED, That our AMA request and recommend that appropriate scientific agencies proceed with necessary research on the health effects of medicinal marijuana.

MSS Position: **Support Resolved 5**

MSS Policy Justifying Position: 95.008MSS Cannabis and the Regulatory Void; 95.003MSS Marijuana: Medical Use and Research

Reference Committee F – AMA Finance and Governance

BOT Report 1 – Annual Report

MSS Position: **Support**

MSS Policy Justifying Position: None

BOT Report 4 – AMA 2017 Dues

The Board of Trustees recommends no change to the dues levels for 2017, that the following be adopted and that the remainder of this report be filed:

Regular Members \$ 420

Physicians in Their Second Year of Practice \$ 315

Physicians in Military Service \$ 280

Physicians in Their First Year of Practice \$ 210

Semi-Retired Physicians \$ 210

Fully Retired Physicians \$ 84

Physicians in Residency Training \$ 45

Medical Students \$ 20

MSS Position: **Support**

MSS Policy Justifying Position: 655.031MSS Reevaluating AMA-MSS Membership Benefits; 655.025MSS Increasing the Efficiency of Student Membership Application Processing

BOT Report 18 – Increasing Collaboration Between Physicians and the Public to Address Problems in Health Care Delivery

The Board of Trustees recommends that AMA Policy H-160.904, "Increasing Collaboration Between Physicians and the Public to Address Problems in Health Care Delivery," be amended by substitution to read as follows and that the remainder of the report be filed:

Our American Medical Association will continue to consider and implement the most strategic and sustainable approaches to stay engaged with physician and non-physician stakeholders essential to our endeavor to improve the delivery of quality medical care.

MSS Position: **Support**

MSS Policy Justifying Position: 270.022MSS Promoting Transparency to Stimulate Improved Quality; 295.167MSS Quality Improvement Education in Medical Schools and Residency Programs

Report of the House of Delegates Committee on Compensation of the Officers

The Committee on Compensation of the Officers recommends that the following be adopted and the remainder of the report filed.

1. That there be no changes to the Officers' compensation for the period beginning July 1, 2016 through June 30, 2017.

MSS Position: **Support**

MSS Policy Justifying Position: None

601 – Childcare at the AMA Meetings

RESOLVED, That our American Medical Association survey recent attendees of the AMA Section meetings as well as the HOD on whether or not they have brought their children to AMA meetings and on the desire and need for onsite childcare and report back on these results at the 2016 Interim Meeting.

MSS Position: **Support with amendment to survey all AMA members**

MSS Policy Justifying Position: 60.021MSS Implementation and Funding of Childcare Services for Patients; 295.057MSS Child Care Resource Information for Medical Students; 295.072MSS Emergency Child Care

604 – Laymen's Medical Advice Policy

RESOLVED, That our American Medical Association support a public campaign to promote patient recognition that when seeking medical advice, they are best served through partnership with their personal physician.

MSS Position: **Support**

MSS Policy Justifying Position: 140.030MSS Ethical Physician Conduct in the Media; 140.002MSS Bioethical Determinations

608 – Including Medical Students in STEPS Forward to Prevent Burn Out and Promote STEPS Forward in Medical Schools Nationwide

RESOLVED, That our American Medical Association modify the STEPS Forward program to include medical students; and be it further

RESOLVED, That our AMA promote the STEPS Forward program as a tool to implement strategies to prevent burnout in medical schools nationwide; and be it further

RESOLVED, That our AMA encourage medical students to promote the STEPS Forward program within medical schools.

MSS Position: **Support**

MSS Policy Justifying Position: 345.005MSS Increased Emphasis on Mental Health and Psychosocial Support in Medical School Curriculum; 345.009MSS Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools; 295.001MSS Support Groups; formal support for D-310.968 Physician and Medical Student Burnout

Reference Committee G – Medical Practice

CMS Report 5 – Virtual Supervision of “Incident to” Services

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 713-A-15, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) supports pilot programs in the Medicare program to enable virtual supervision of “incident to” services that require direct supervision if they abide by the following principles:

a) The physician billing “incident to” must fulfill other requirements of direct supervision of “incident to” services, including first seeing the patient and initiating the course of treatment, and providing subsequent services at a rate that shows active participation in and management of the course of treatment.

b) The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services.

c) Non-physician practitioners and employees providing “incident to” services must follow existing requirements for the provision of “incident to” services, including abiding by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.

d) The delivery of “incident to” services must be consistent with state scope of practice laws.

e) Virtual supervision of “incident to” services must require the supervising physician to be connected through real-time audio and video technology with the room in which the “incident to” service is provided, to ensure that the physician is immediately able to provide assistance and direction during the provision of the service.

f) Virtual supervision of “incident to” services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.

g) Physicians providing virtual supervision of “incident to” services should visit the sites in person where patients receive procedures from non-physician practitioners or employees.

h) Physicians providing virtual supervision of “incident to” services must establish protocols for arranging for emergency services, including having an agreement with a physician at the site at which “incident to” services are provided, to ensure the provision of immediate assistance.

i) Patients receiving “incident to” services that are virtually supervised must have access to the certification, licensure and/or board certification qualifications of the health care practitioners who are providing and supervising the care in advance of their visit.

2. That our AMA encourages national medical specialty societies to develop best practices and protocols for virtual supervision of “incident to” services, including specifying which services and procedures would not qualify for this practice.

MSS Position: **Support**

MSS Policy Justifying Position: 480.001MSS Medical Technology Assessment; 480.010MSS Web-Based Tele-Health Initiatives and Possible Interference with the Traditional Physician-Patient Relationship

CMS Report 7 – Prior Authorization Simplification and Standardization

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

1. That our American Medical Association (AMA) reaffirm Policies D-330.909 and D-320.988, which call for study of the time burdens associated with administrative tasks such as prior authorization (PA).
2. That our AMA reaffirm Policies H-130.970, H-285.998, and H-320.968, which address the timeliness of health plans' responses to PA requests and prohibit PA requirements for emergency services.
3. That our AMA reaffirm Policy H-320.961, which calls for the AMA to support legislation or regulations that would prevent the retrospective denial of payment for any services for which a physician previously obtained PA.
4. That our AMA reaffirm Policies H-320.944 and Policy H-160.906, which call for the AMA to support the adoption of standard electronic transactions to facilitate PA automation.
5. That our AMA address the negative impact of medication step therapy programs on patient access to needed treatment by supporting state legislation that places limitations and restrictions around the use of such programs and their interference with a physician's best clinical judgement.
6. That our AMA, in collaboration with state medical associations and national medical specialty societies and relevant patient groups, create a set of best practices for PA and possible alternative approaches to utilization control; advocate that accreditation organizations include these concepts in their program criteria; and urge health plans to abide by these best practices in their PA programs and to pilot PA alternative programs.

MSS Position: **Support**

MSS Policy Justifying Position: 120.012MSS Prior Authorization Reform; 95.010MSS Eliminating “Fail First” Policy in Addiction Treatment

702 – Study of Current Trends in Clinical Documentation

RESOLVED, That our American Medical Association study how modern clinical documentation requirements, methodologies, systems, and standards have affected the quality and content of clinical documentation; and be it further

RESOLVED, That our AMA study current practices for clinical documentation training for physicians as well as in graduate and undergraduate medical education.

MSS Position: **Support**

MSS Policy Justifying Position: 165.018MSS Study of Current Trends in Clinical Documentation (HOD resolution is MSS-authored)

703 – Voluntary Reporting of Complications from Medical Tourism

RESOLVED, That our American Medical Association ask the appropriate organizations to maintain a de-identified database for the voluntary reporting of outcomes resulting from medical procedures performed abroad.

MSS Position: **Support**

MSS Policy Justifying Position: 250.025MSS Voluntary Reporting of Complications from Medical Tourism (HOD resolution is MSS-authored)

704 – Stem Cell Tourism

RESOLVED, That our AMA (1) study best practices for physicians to advise patients seeking to engage in stem cell tourism and how to guide them in risk assessment; and (2) encourage further research on stem cell tourism, and urge physicians to educate themselves on these issues.

MSS Position: **Support**

MSS Policy Justifying Position: 170.017MSS Stem Cell Tourism (HOD resolution is MSS-authored)

712 – Remove Pricing Barriers to Treatment for Hepatitis C (HCV)

RESOLVED, That our American Medical Association advocate with Congress and federal agencies, for any necessary combination of legislation, regulation, negotiation with the pharmaceutical industry, and federal subsidies, to lower the cost of treatment for all Americans infected with Hepatitis C virus using highly effective oral medications, to a price level that would make treatment affordable and accessible.

MSS Position: **Support**

MSS Policy Justifying Position: 440.040MSS Increased Advocacy for Hepatitis C Virus Education, Prevention, Screening, and Treatment; 100.014MSS Drug Pricing Reform; formal support for H-110.988 Controlling the Skyrocketing Costs of Generic Prescription Drugs; formal support for H-110.996 Cost of Prescription Drugs

Reference Committee on Constitution and Bylaws

BOT Report 7 – Supporting Autonomy for Patients with Differences of Sex Development

The Board of Trustees recommends that the following be adopted in lieu of Resolution 3-A-16 and the remainder of this report be filed:

That our American Medical Association support optimal management of DSD through individualized, multidisciplinary care that: (1) seeks to foster the well-being of the child and the adult he or she will become; (2) respects the rights of the patient to participate in decisions and, except when life-threatening circumstances require emergency intervention, defers medical or surgical intervention until the child is able to participate in decision making; and (3) provides psychosocial support to promote patient and family well-being.

MSS Position: **Support**

MSS Policy Justifying Position: 245.020MSS Supporting Autonomy for Patients with Differences of Sex Development

CEJA Report 1 – Collaborative Care

In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, protecting the integrity of the patient-physician relationship, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.

An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As leaders within health care teams, physicians individually should:

(a) Model ethical leadership by:

- (i) understanding the range of their own and other team members' skills and expertise and roles in the patient's care;
- (ii) clearly articulating individual responsibilities and accountability;
- (iii) encouraging insights from other members and being open to adopting them; and

(iv) mastering broad teamwork skills.

(b) Promote core team values of honesty, discipline, creativity, humility, and curiosity and commitment to continuous improvement.

(c) Help clarify expectations to support systematic, transparent decision making.

(d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member's opinion is heard and considered and team members share accountability for decisions and outcomes.

(e) Communicate appropriately with the patient and family and respect their unique relationship as members of the team.

As leaders within health care institutions, physicians individually and collectively should:

(f) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.

(g) Encourage their institutions to identify and constructively address barriers to effective collaboration.

(h) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.

MSS Position: **Support**

MSS Policy Justifying Position: 160.014MSS Recognizing the Important Role of Physician Extenders in the Multidisciplinary Patient Care Team; 385.002MSS The Patient-Centered Medical Home Concept; 295.177MSS Shared Decision-Making in Medical Education; formal support for H-160.919 Principles of the Patient-Centered Medical Home

001 – Support for the Decriminalization and Treatment of Suicide Attempts Amongst Military Personnel

RESOLVED, That our American Medical Association support efforts to decriminalize suicide attempts in the military; and be it further

RESOLVED, That our AMA support efforts to provide treatment for survivors of suicide attempt in lieu of punishment in the military.

MSS Position: **Support**

MSS Policy Justifying Position: 340.010MSS Support for the Decriminalization and Treatment of Suicide Attempts Amongst Military Personnel (HOD resolution is MSS-authored)

002 – Living Organ Donation at the Time of Imminent Death

RESOLVED, That our American Medical Association study the implications of the removal of barriers to living organ donation at the time of imminent death.

MSS Position: **Support**

MSS Policy Justifying Position: 370.017MSS Living Organ Donation at the Time of Imminent Death (HOD resolution is MSS-authored)

003 – Study of the Current Uses and Ethical Implications of Expanded Access Programs

RESOLVED, That our American Medical Association study the implementation of expanded access programs, accelerated approval mechanisms, and payment reform models meant to increase access of experimental therapies; and be it further

RESOLVED, That our AMA study the ethics of expanded access programs, accelerated approval mechanisms, and payment reform models meant to increase access of experimental therapies.

MSS Position: **Support**

MSS Policy Justifying Position: 140.032MSS Study of the Current Uses and Ethical Implications of Expanded Access Programs (HOD resolution is MSS-authored)

004 – Addressing Patient Spirituality in Medicine

RESOLVED, That our American Medical Association support inquiry into, as well as discussion and consideration of, individual patient spirituality as an important component of health; and be it further

RESOLVED, That our AMA encourage expanded patient access to spiritual care services and resources beyond trained healthcare professionals.

MSS Position: **Support**

MSS Policy Justifying Position: 65.021MSS Addressing Patient Spirituality in Medicine (HOD resolution is MSS-authored)

005 – No Compromise on Anti-Female Genital Mutilation Policy

RESOLVED, That our American Medical Association reaffirm its policy against female genital mutilation (FGM); and be it further

RESOLVED, That, due to the public debate in 2016 over whether the medical community sanctions a proposed 'nicking procedure,' our AMA must further clarify its current position on FGM to explicitly state that our AMA condemns any and all ritual procedures including, but not limited to, 'nicking' or 'genital alteration' procedures done to the genitals of women and girls; and be it further

RESOLVED, That our AMA, on behalf of the medical community, actively advocate against the practice of FGM in all its forms (including the recently proposed 'nicking' and 'alteration' procedures) and

effectively add the voice of America's physicians to the voices of many anti-FGM human rights activists and their organizations which advocate for the survivors and victims of FGM; and be it further

RESOLVED, That our AMA partner in this public advocacy with reputable anti-FGM activists and survivors including, but not limited to, Jaha Dukureh of the Tahirih Justice Center, Waris Dirie of Desert Flower Foundation, Layla Hussein of the Maya Center and the Dahlia Project, and Nimco Ali of the Daughters of Eve or Safe Hands for Girls to name a few; and be it further

RESOLVED, That our AMA educate its membership and the American public about the harm of FGM prominently through its website and provide resources about the ethics and medical harm of any and all forms of FGM.

MSS Position: **Support**

MSS Policy Justifying Position: 525.002MSS Surgical Modification of Female Genitalia

008 – Blood Donor Deferral Criteria

RESOLVED, That our AMA amend AMA policy H-50.973 by addition and deletion to read as follows:

Blood Donor Deferral Criteria H-50.973

AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their level of individual risk; ~~and~~ (2) opposes ~~the current lifetime a~~ deferral on blood and tissue donations from men who have sex with men not based in science; and (3) supports research into Individual Risk Assessment criteria for blood donation.

RESOLVED, That our AMA advocate for the elimination of current deferral policy and ask the Food and Drug Administration to develop recommendations for Individual Risk Assessment during the public commentary period.

MSS Position: **Support**

MSS Policy Justifying Position: 50.004MSS Blood Donor Deferral Criteria Revisions (HOD resolution is MSS-authored)

Reference Committee B – Legislative Advocacy

BOT Report 2 – AMA Support for State Medical Societies' Efforts to Implement MICRA-type Legislation

The Board of Trustees recommends that the following be adopted in lieu of Resolution 214-I-15 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy H-435.967, "Report of the Special Task Force and the Advisory Panel on Professional Liability."

2. That our AMA support the efforts of interested state medical associations to defeat efforts to replace a state medical liability system with a no-fault liability or Patient Compensation System.

MSS Position: **Support Resolved 1, oppose Resolved 2**

MSS Policy Justifying Position: 435.004MSS A No-Fault Professional Liability System; 435.010MSS Quantifying Medical Tort Reform; formal support for H-435.967 Report of the Special Task Force and the Advisory Panel on Professional Liability; formal support for D-435.984 Tort Reform

201 – Removing Restrictions on Federal Funding for Firearm Violence Research

RESOLVED, That our American Medical Association 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.

MSS Position: **Support**

MSS Policy Justifying Position: 460.019MSS Removing Restrictions on Federal Funding for Firearm Research (HOD resolution is MSS-authored)

202 – Inclusion of Sexual Orientation and Gender Identity Information in Electronic Health Records

RESOLVED, That our American Medical Association advocate for inclusion of sexual orientation and gender in electronic health records (EHRs).

MSS Position: **Support**

MSS Policy Justifying Position: 315.005MSS Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation

203 – Universal Prescriber Access to Prescription Drug Monitoring Programs

RESOLVED, That our American Medical Association support legislation and regulatory action that would authorize all prescribers of controlled substances, including residents, to have access to their state prescription drug monitoring program.

MSS Position: **Support**

MSS Policy Justifying Position: **Caucus vote taken to support (2/3)**; 120.009MSS Restrictions on Use of Physician Prescribing Data for Commercial Purposes

205 – AMA Study of the Affordable Care Act

RESOLVED, That our American Medical Association study, and using our extensive HOD policy, identify what needs to be changed/fixed with the ACA; and be it further

RESOLVED, That our AMA compile a policy compendium of AMA HOD Policy or links to that policy, to provide to legislators, think tanks, and the public with reliable accurate ideas and knowledge; and be it further

RESOLVED, That a comprehensive report on how to change and improve the ACA be presented back to the House of Delegates at the 2017 Annual Meeting.

MSS Position: **Support**

MSS Policy Justifying Position: 165.007MSS Steps in Advancing towards Affordable Universal Access to Health Insurance; 165.009MSS Evaluation of the Principles of the Health Care Access Resolution; 165.012MSS Covering the Uninsured as AMA's Top Priority; 165.015MSS Maintaining Insurance Coverage and Empowering State Choice; 165.004MSS Health Insurance Premium Subsidies for Affordable Universal Coverage

206 – Advocacy and Studies on Affordable Care Act Section 1332 (State Innovation Waivers)

RESOLVED, That our American Medical Association advocate that the “deficit-neutrality” component of the current HHS rule for Section 1332 waiver qualification be considered only on long-term, aggregate cost savings of states’ innovations as opposed to having costs during any particular year, including in initial “investment” years of a program, reduce the ultimate likelihood of waiver approval; and be it further

RESOLVED, That our AMA study reforms that can be introduced under Section 1332 of the Affordable Care Act in isolation and/or in combination with other federal waivers to improve healthcare benefits, access and affordability for the benefit of patients, healthcare providers and states, and encourages state societies to do the same.

MSS Position: **Support**

MSS Policy Justifying Position: 270.030MSS Advocacy and Studies on ACA Section 1332 (State Innovation Waivers) to Improve States’ Abilities to Innovate and Improve Healthcare Benefits, Access and Affordability (HOD resolution is MSS-authored)

209 – Affordable Care Act Revisit

RESOLVED, That our American Medical Association House of Delegates no longer support the Affordable Care Act (ACA) in its current form and to work for replacement or substantial revision of the act to include these changes:

- Allowing health insurance to be sold across state lines
- Allowing all businesses to self-insure and to purchase insurance through business health plans or association health plans

- Improving the individual mandate with a refundable tax credit that would be used to purchase health insurance
- Improving health-related savings accounts so as to help ACA insureds afford their higher deductibles and co-pays
- Reversing cuts to traditional Medicare and Medicare Advantage programs
- Encouraging states to develop alternatives to Medicaid by using federal funds granted under provisions of the ACA
- Eliminating all exemptions, loopholes, discounts, subsidies and other schemes to be fair to those who cannot access such breaks in their insurance costs; and be it further

RESOLVED, That our AMA maintain the following provisions to the ACA if it is replaced:

- Full coverage of preventive services
- Family insurance coverage of children living in a household until age 26
- Elimination of lifetime benefit caps
- Guaranteed insurability

MSS Position: **Oppose**

MSS Policy Justifying Position: 165.007MSS Steps in Advancing towards Affordable Universal Access to Health Insurance; 165.009MSS Evaluation of the Principles of the Health Care Access Resolution; 165.012MSS Covering the Uninsured as AMA's Top Priority; 165.019MSS Protecting Patient Access to Health Insurance and Affordable Care; 165.015MSS Maintaining Insurance Coverage and Empowering State Choice; 165.004MSS Health Insurance Premium Subsidies for Affordable Universal Coverage; 160.022MSS Reducing Barriers to Preventive Health Care Delivery and Compensation; formal support for H-165.848 Individual Responsibility To Obtain Health Insurance; formal support for H-165.855 Medical Care for Patients with Low Incomes

212 – Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation

RESOLVED, That our American Medical Association support the inclusion of a patient's biological sex, gender identity, sexual orientation, preferred gender pronoun(s), and (if applicable) surrogate identifications in medical documentation and related forms in a culturally-sensitive and voluntary manner; and be it further

RESOLVED, That our AMA advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health.

MSS Position: **Support**

MSS Policy Justifying Position: 315.005MSS Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation (HOD resolution is MSS-authored)

214 – Firearm-Related Injury and Death: Adopt a Call to Action

RESOLVED, That our American Medical Association endorse 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 Congress 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.

MSS Position: **Support**

MSS Policy Justifying Position: 145.001MSS Handgun Violence; 145.012MSS Use of Individualized Violence Risk Assessments in Reporting of Mental Health Professionals for Firearm Background Checks; 145.013MSS Strengthening our Gun Policies on Background Checks and the Mentally Ill; 270.004MSS Policy on the "Gag Rule"; 145.004MSS Prevention of Unintentional Firearm Accidents in Children; 145.011MSS Gun Safety Counseling in Undergraduate Medical Education; formal support for H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care; formal support for H-145.997 Firearms as a Public Health Problem in the United States - Injuries and Death; formal support for H-145.984 Data on Firearm Deaths and Injuries; formal support for D-145.999 Epidemiology of Firearm Injuries

215 – Parental Leave

RESOLVED, That our American Medical Association study the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act:

- a reduction in the number of employees from 50 employees;
- an increase in the number of covered weeks from 12 weeks; and
- creating a new benefit of paid parental leave.

RESOLVED, That our AMA study the effects of FMLA expansion on physicians in varied practice environments.

MSS Position: **Support**

MSS Policy Justifying Position: 270.032 Paid Parental Leave; 270.003MSS Broadening Access to Paid Family Leave to Improve Health Outcomes and Health Disparities; 310.049MSS Equal Paternal and Maternal Leave for Medical Residents

223 – Emergency Post Election Support for Principles of the Patient Protection and Affordable Care Act

RESOLVED, That our American Medical Association make a public statement that any health care reform legislation considered by Congress ensure continued improvement in patient access to care and patient health insurance coverage by maintaining:

- 1) Guaranteed insurability, including those with pre-existing conditions, without medical underwriting,
- 2) Income-dependent tax credits to subsidize private health insurance for eligible patients,
- 3) Federal funding for the expansion of Medicaid to 138% of the federal poverty level in states willing to accept expansion, as per current AMA policy (D-290.979),
- 4) Maintaining dependents on family insurance plans until the age of 26,
- 5) Coverage for preventive health services,
- 6) Medical loss ratios set at no less than 85% to protect patients from excessive insurance costs.

MSS Position: **Support**

MSS Policy Justifying Position: 165.019MSS Protecting Patient Access to Health Insurance and Affordable Care; 165.007MSS Steps in Advancing towards Affordable Universal Access to Health Insurance; 165.009MSS Evaluation of the Principles of the Health Care Access Resolution; 165.012MSS Covering the Uninsured as AMA's Top Priority; 165.015MSS Maintaining Insurance Coverage and Empowering State Choice; 165.004MSS Health Insurance Premium Subsidies for Affordable Universal Coverage; 160.022MSS Reducing Barriers to Preventive Health Care Delivery and Compensation; formal support for H-165.848 Individual Responsibility To Obtain Health Insurance; formal support for H-165.855 Medical Care for Patients with Low Incomes

224 – Protecting Patient Access to Health Insurance and Affordable Care

RESOLVED, That our American Medical Association advocate that any health care reform legislation considered by Congress ensures continued improvement in patient access to care and patient health insurance coverage by maintaining: (1) Guaranteed insurability, including those with pre-existing conditions, without medical underwriting, (2) Income-dependent tax credits to subsidize private health insurance for eligible patients, (3) Federal funding for the expansion of Medicaid to 138% of the federal poverty level in states willing to accept expansion, as per current AMA policy (D-290.979), (4) Maintaining dependents on family insurance plans until the age of 26, (5) Coverage for preventive health services, (6) Medical loss ratios set at no less than 85% to protect patients from excessive insurance costs; and (7) Coverage for mental health and substance use disorder services at parity with medical and surgical benefits.

MSS Position: **Support**

MSS Policy Justifying Position: 165.019MSS Protecting Patient Access to Health Insurance and Affordable Care (HOD resolution is MSS-authored)

226 – Continuing AMA Advocacy on the Patient Protection and Affordable Care Act

RESOLVED, That our American Medical Association actively and in a timely manner engage the new Administration in discussions about the future of the Patient Protection and Affordable Care Act, emphasizing the AMA's body of policy on health system reform.

MSS Position: **Support**

MSS Policy Justifying Position: 165.019MSS Protecting Patient Access to Health Insurance and Affordable Care; 165.007MSS Steps in Advancing towards Affordable Universal Access to Health Insurance; 165.009MSS Evaluation of the Principles of the Health Care Access Resolution; 165.012MSS Covering the Uninsured as AMA's Top Priority; 165.015MSS Maintaining Insurance Coverage and Empowering State Choice; 165.004MSS Health Insurance Premium Subsidies for Affordable Universal Coverage

Reference Committee C – Medical Education

CME Report 1 – Access to Confidential Health Services for Medical Students and Physicians

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolutions 901-I-15, 913-I-15, and 304-A-16, and the remainder of the report be filed.

1. That our American Medical Association (AMA) ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

- 1) Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care and mental health counseling services that: a) include appropriate follow-up; b) are outside the trainees' grading and evaluation pathways; and c) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
- 2) Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
- 3) Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
- 4) Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

2. That our AMA urge state medical boards to accept “safe haven” non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. That Policy H-345.973, “Mental Health Services for Medical Students and Resident and Fellow Physicians,” be amended by addition and deletion, as follows.

Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians

Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place.

4. That Policy H-295.872, “Expansion of Student Health Services,” be rescinded, as it is (in part) already reflected in current LCME standards and (in part) now incorporated into Policy H-345.973, Mental Health Services for Medical Students and Resident and Fellow Physicians.
5. That Policy D-405.992, “Physician Health and Wellness,” and D-405.996, “Physician Well-Being and Renewal,” be rescinded, as these directives have been accomplished, are superseded by other policy, or are no longer relevant.
6. That Policy D-405.983, “Medical Students and Residents as Patients,” be rescinded, as having been fulfilled by this report.

MSS Position: **Support with amendment- “That our AMA encourage medical schools to create mental health awareness and suicide prevention screening programs that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation.”**

MSS Policy Justifying Position: 345.009MSS Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools; 140.031MSS Accommodations for Treatment of Medical Students and Resident; 345.004MSS Stigmatization of Mental Health Disorders within the Medical Profession; 345.007MSS Improving Physician Mental Health and Reducing Stigma through Revision of Medical Licensure Applications; 315.002 MSS Privacy of Student Electronic Medical Records at Medical School Affiliated Hospitals; 295.164MSS Medical Student Access to Comprehensive Mental Health and Substance Abuse Treatment; 295.137MSS Expansion of Student Health Services

302 – Protecting the Rights of Breastfeeding Resident and Fellows

RESOLVED, That our American Medical Association work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME), to mandate language in housestaff

manuals or similar policy references of all training programs on the protected time and locations for milk expression and storage of breast milk; and be it further

RESOLVED, That our AMA work with appropriate bodies, such as the ACGME and the Association of American Medical Colleges, to include language related to the learning and work environments for breast feeding mothers in regular program reviews.

MSS Position: **Support**

MSS Policy Justifying Position: 245.002MSS AMA Support for Breastfeeding; 245.013MSS Promoting Breastfeeding in Hospitals; 270.017MSS Support for Legislation for Businesses to Provide Breastfeeding Employees Time, Facilities and Equipment for Breastfeeding; formal support for H-245.982 AMA Support for Breastfeeding

303 – Primary Care and Mental Health Training in Residency

RESOLVED, That our American Medical Association advocate for the incorporation of integrated mental health and primary care services into existing psychiatry and primary care training programs' clinical settings; and be it further

RESOLVED, That our AMA encourage primary care and psychiatry residency training programs to create and expand opportunities for residents to obtain clinical experience working in an integrated mental health and primary care model, such as the collaborative care model; and be it further

RESOLVED, That our AMA advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.

MSS Position: **Support**

MSS Policy Justifying Position: 345.003MSS Improving Pediatric Mental Health Screening; 345.005MSS Increased Emphasis on Mental Health and Psychosocial Support in Medical School Curriculum

304 – Improving Access to Care and Health Outcomes

RESOLVED, That our American Medical Association support training opportunities for students and residents to learn cultural competency from community health workers.

MSS Position: **Support**

MSS Policy Justifying Position: 200.018MSS Incorporating Community Health Workers into the U.S. Health Care System; 295.081MSS Promoting Culturally Competent Health Care

305 – Privacy Personal Use and Funding of Mobile Devices

RESOLVED, That our American Medical Association encourage further research in integrating mobile devices in clinical care, particularly to address challenges of reducing work burden while maintain clinical autonomy for residents and fellows; and be it further

RESOLVED, That our AMA collaborate with the Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure a more uniform regulation of mobile devices in medical education and clinical training; and be it further

RESOLVED, That our AMA encourage medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines in using personal devices in clinical environment.

MSS Position: **Support Resolved 1**

MSS Policy Justifying Position: 480.017MSS Secure Text Messaging Between Healthcare Providers; 480.001MSS Medical Technology Assessment; 480.009MSS Safe, Effective Smartphone Applications; 480.012MSS Preserving the Role of Physicians and Patients in the Evolution of Health Information Technology; 480.013MSS The Role of Medical Students in the Development of Health Information Technology

308 – Promoting and Reaffirming Domestic Medical School Clerkship Education

RESOLVED, That our AMA pursue legislative and/or regulatory avenues that promote the regulation of the financial compensation which medical schools can provide for clerkship positions in order to facilitate fair competition amongst medical schools and prevent unnecessary increases in domestically-trained medical student debt; and be it further

RESOLVED, That our AMA support the expansion of partnerships of foreign medical schools with hospitals in regions which lack local medical schools in order to maximize the cumulative clerkship experience for all students; and be it further

RESOLVED, That our AMA reaffirm policies D-295.320, D-295.931, and D-295.937.

MSS Position: **Support**

MSS Policy Justifying Position: 295.187MSS Promoting and Reaffirming Domestic Medical School Clerkship Education (HOD resolution is MSS-authored)

312 – Eliminating the Tax Liability for Payment of Student Loans

RESOLVED, That our American Medical Association work with the Internal Revenue Service to eliminate the tax liability when private employers provide the funds to repay student loans for physicians who agree to work in an underserved area.

MSS Position: **Support**

MSS Policy Justifying Position: 305.001MSS Medical Student Loan Program; 305.003MSS Loan Forgiveness Program; 305.008MSS Voluntary Service-Payback Programs; 305.077MSS Increasing Public Service Opportunities for Specialists; 305.080MSS Novel Mechanism to Reduce Medical Student Debt

Reference Committee F – Finance and Governance

CLRPD Report 1 – Minority Affairs Section and Integrated Physician Practice Section, Five-Year Reviews

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Minority Affairs Section and the Integrated Physician Practice Section through 2021 with the next review no later than the 2021 Interim Meeting and that the remainder of this report be filed.

MSS Position: **Support**

MSS Policy Justifying Position: 295.005MSS Availability of Medical Education; 350.001MSS Minority and Disadvantaged Medical Student Recruitment and Retention Programs; 350.003MSS Minority Representation in the Medical Profession; 350.011MSS Continued Support for Diversity in Medical Education; formal support for H-350.979 Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession; formal support for D-200.985 Strategies for Enhancing Diversity in the Physician Workforce

602 – Equality

RESOLVED, That all future meetings and conferences organized and/or sponsored by our American Medical Association, not yet contracted, only be held in towns, cities, counties, and states that do not have discriminatory policies based on race, color, religion, ethnic origin, national origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age.

MSS Position: **Support referral**

MSS Policy Justifying Position: **Caucus vote taken to support referral (2/3)**; 65.002MSS Nondiscrimination Based on Sexual Orientation

603 – Support a Study on the Minimum Competencies and Scope of Medical Scribe Utilization

RESOLVED, That our American Medical Association partner with The Joint Commission and other stakeholders to study the minimum skills and competencies required of a medical scribe regarding documentation performance and clinical boundaries of medical scribe utilization.

MSS Position: **Support**

MSS Policy Justifying Position: 275.012MSS Support A Study on the Minimum Competencies and Scope of Medical Scribe Utilization (HOD resolution is MSS-authored)

Reference Committee J – Medical Service, Medical Practice, and Insurance

CMS Report 1 – Infertility Benefits for Veterans

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 223-I-15 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. That our AMA encourage interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. That our AMA encourage the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. That our AMA support efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.

MSS Position: **Support**

MSS Policy Justifying Position: 520.005MSS Ensuring High Quality Care for All Veterans and Their Families; formal support for H-510.985 Access to Health Care for Veterans; formal support for H-510.991 Veterans Administration Health System

CMS Report 2 – Health Care while Incarcerated

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 118-A-16 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy D-430.997, which supports the accreditation standards developed by the National Commission on Correctional Health Care (NCCHC) to improve the quality of physical and behavioral health care services to incarcerated individuals and encourages all correctional systems to support NCCHC accreditation.
2. That our AMA advocate for adequate payment to health care providers, including primary care and mental health professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
3. That our AMA support partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for individuals in the correctional system.
4. That our AMA encourage state Medicaid agencies to accept and process Medicaid applications from individuals who are incarcerated.

5. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated individuals who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
6. That our AMA encourage states to suspend rather than terminate an individual's Medicaid eligibility upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
7. That our AMA rescind Policy D-430.994, which requested the study accomplished by this report.

MSS Position: **Support**

MSS Policy Justifying Position: 20.010MSS Comprehensive HIV Programs in Correctional Facilities; 95.006MSS Comprehensive Evidence-Based Drug Treatment in Prisons; 315.004MSS Implementing the Use of EHR in Jail Health Services; 345.006MSS Reduced Incarceration and Improved Treatment of Individuals with Mental Illness or Illicit Drug Dependence; formal support for H-430.988 Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities

CMS Report 4 – Concurrent Hospice and Curative Care

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 804-I-15 and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-85.966, which maintains that hospice care should provide the patient and family with appropriate physical and emotional support, but not preclude the use of appropriate palliative therapies to continue to treat underlying disease.
2. That our AMA support continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent hospice, palliative and curative care.
3. That our AMA encourage CMS to identify ways to optimize patient access to palliative care, which relieves suffering and improves quality of life for people with serious illnesses, regardless of whether they can be cured, and to provide appropriate coverage and payment for these services.
4. That our AMA encourage physicians to be familiar with local hospice and palliative care resources and their benefit structures, and to refer seriously ill patients accordingly.

MSS Position: **Support**

MSS Policy Justifying Position: 160.031MSS Concurrent Hospice and Life-Prolonging Care; formal support for H-55.999 Symptomatic and Supportive Care for Patients with Cancer

CMS Report 5 – Incorporating Value into Pharmaceutical Pricing

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 712-A-16, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policies H-155.960 and H-185.939, which support the use of value-based insurance design, determining patient cost-sharing requirements based on the clinical value of a treatment.
2. That our AMA reaffirm Policy H-450.933, which establishes guidelines to help maximize opportunities for clinical data registries to enhance the quality of care provided to patients.
3. That our AMA reaffirm Policies H-460.909 and D-390.961 in support of adequate investments in comparative effectiveness research.
4. That our AMA support value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles:
 - a) Value-based prices of pharmaceuticals should be determined by objective, independent entities;
 - b) Value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes;
 - c) Processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role;
 - d) Processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients;
 - e) Processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and
 - f) Value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.
5. That our AMA support the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research.
6. That our AMA support direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.

MSS Position: **Support**

MSS Policy Justifying Position: 460.011MSS Comparative Effectiveness Research; 100.014MSS Drug Pricing Reform; 480.001MSS Medical Technology Assessment; formal support for D-330.954 Prescription Drug Prices and Medicare

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

1. That our American Medical Association (AMA) reaffirm Policy H-480.946, which outlines principles to guide the appropriate coverage of and payment for telemedicine services.
2. That our AMA reaffirm Policy H-100.980, which supports a strong and adequately funded US Food and Drug Administration to ensure that safe and effective medical products are made available to the American public as efficiently as possible.
3. That our AMA support the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that:
 - a) support the establishment or continuation of a valid patient-physician relationship;
 - b) have a clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness;
 - c) follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes;
 - d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication;
 - e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models;
 - f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app;
 - g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and
 - h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.
4. That our AMA support that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.
5. That our AMA encourage the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.
6. That our AMA encourage the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.

7. That our AMA encourage physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.
8. That our AMA encourage physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks.
9. That our AMA assess the potential liability risks to physicians for using, recommending, or prescribing mHealth apps, including risk under federal and state medical liability, privacy, and security laws.
10. That our AMA support further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.
11. That our AMA encourage national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.

MSS Position: **Support**

MSS Policy Justifying Position: 140.029 Ethical Parameters for Recommending Mobile Medical Applications; 480.009MSS Safe, Effective Smartphone Applications; 480.001MSS Medical Technology Assessment; 480.017MSS Secure Text Messaging Between Healthcare Providers; formal support for D-480.975 Guidelines for Mobile Medical Applications and Devices

801 – Increasing Access to Medical Devices for Insulin-Dependent Diabetics

RESOLVED, That our American Medical Association work with relevant stakeholders to encourage the development of plans for inclusion in the Medicare Advantage Value Based Insurance Design Model that reduce copayments/coinsurance for diabetes prevention, medication, supplies, and equipment including pumps and continuous glucose monitors, while adhering to the principles established in AMA Policy, Value-Based Insurance Design, H-185.939.

MSS Position: **Support**

MSS Policy Justifying Position: 180.017MSS Increasing Access to Medical Devices for Insulin-Dependent Diabetics (HOD resolution is MSS-authored)

802 – Eliminating Fail First Policy in Addiction Treatment

RESOLVED, That our American Medical Association advocate for the elimination of the "fail first" policy implemented by insurance companies for addiction treatment.

MSS Position: **Support**

MSS Policy Justifying Position: 95.010MSS Eliminating "Fail First" Policy in Addiction Treatment (HOD resolution is MSS-authored)

804 – Parity in Reproductive Health Insurance Coverage for Same-Sex Couples

RESOLVED, That our American Medical Association support parity in insurance coverage for fertility treatments for same-sex couples, when insurance provides coverage for fertility treatments; and be it further

RESOLVED, That our AMA support local and state efforts to promote parity in reproductive health insurance coverage for same-sex couples when insurance provides coverage for fertility treatments.

MSS Position: **Support**

MSS Policy Justifying Position: 65.008MSS Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population; 65.009MSS Same-Sex and/or Opposite Sex Non-Married Partner; 65.013MSS Marriage-Based Health Disparities Among Gay, Lesbian, Bisexual, and Transgender Families; 65.014MSS Marriage Equality and Repeal of the Defense of Marriage Act

808 – A Study on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey and Healthcare Disparities

RESOLVED, That our American Medical Association study the potential healthcare disparities caused by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in Medicare reimbursement.

MSS Position: **Support**

MSS Policy Justifying Position: 390.005MSS Opposing Medicare Reimbursement Based Off of Patient Satisfaction Score (HOD resolution is MSS-authored)

809 – Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers

RESOLVED, That our American Medical Association advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek Federal Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system; and be it further

RESOLVED, That our AMA support the mandatory provision of samples of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays; and be it further

RESOLVED, That our AMA advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs.

MSS Position: **Support**

MSS Policy Justifying Position: 270.031MSS Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers (HOD resolution is MSS-authored)

812 – Enact Rules and Payment Mechanisms to Encourage Appropriate Hospice and Palliative Care Usage

RESOLVED, That our American Medical Association (AMA) amend existing AMA Policy H-85.955, Hospice Care, by addition to read as follows:

Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care; (2) encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment; (3) supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare; (4) believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program; (5) supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers; ~~and~~ (6) advocates that the Centers for Medicare and Medicaid Services enact rules and payment mechanisms to encourage appropriate hospice and palliative care utilization for eligible patients; and (7) seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure.

MSS Position: **Support**

MSS Policy Justifying Position: 160.031MSS Concurrent Hospice and Life-Prolonging Care; formal support for H-55.999 Symptomatic and Supportive Care for Patients with Cancer

Reference Committee K – Science and Public Health

BOT Report 9 – Product-Specific Direct-to-Consumer Advertising of Prescription Drugs

The Board of Trustees recommends that the following statements be adopted in lieu of Second Resolve, Resolution 927-1-15 and Resolution 514-A-16, and the remainder of the report be filed.

1. That Policy H-105.988, “Direct-to-Consumer (DTC) Advertising (DTCA) of Prescription Drugs and Implantable Devices,” be amended by addition and deletion to read as follows:

It is the policy of our AMA:

1. to support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.

2. That until such a ban is in place, 1. That our AMA considers acceptable only those our AMA opposes product-claims specific DTCA advertisements that does not satisfy the following guidelines:

(a) The advertisement should be indication-specific and enhance consumer education about ~~both~~ the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.

(b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.

(c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.

(d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.

(e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.

(f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.

(g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.

(h) In general, ~~product-claims specific DTCA advertisements~~ should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in ~~DTCA advertisements~~, a disclaimer should be prominently displayed.

(i) The use of actual health care professionals, either practicing or retired, in DTCA to endorse a specific drug or implantable medical device product is discouraged but if utilized, the

advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.

(j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.

(k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.

~~2. That our AMA opposes product specific DTC advertisements, regardless of medium, that do not follow the above AMA guidelines.~~

3. That the FDA review and pre-approve all DTCA advertisements for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.

4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTCA.

5. That DTCA advertisements for newly approved prescription drug or implantable medical device products not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population and until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTCA for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it.

6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTCA advertisements.

7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.

8. That our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.

9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-~~claims~~specific DTCA and with the Council on Ethical and Judicial Affairs (~~CEJA~~) Ethical Opinion E-5-0159.6.7 and to adhere to the ethical guidance provided in that Opinion.

10. That the Congress should request the Agency for Healthcare Research and Quality (~~AHRQ~~) or other appropriate entity to perform periodic evidence-based reviews of DTCA in the United States to determine the impact of DTCA on health outcomes and the public health. If DTCA is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTCA regulation or, if necessary, to prohibit DTCA in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.

11. That our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes.

12. That our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTCA, as necessary.

13. That our AMA supports “help-seeking” or “disease awareness” advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA).

2. That Policy H-105.986, “Ban Direct-to-Consumer Advertisements of Prescription Drugs and Implantable Devices,” be rescinded as it is now incorporated into amended Policy H-105.988.

MSS Position: **Support**

MSS Policy Justifying Position: 105.003MSS Opposing Tax Deductions for Direct To Consumer Advertising; 295.130MSS Educating Medical Students about the Pharmaceutical Industry; formal support for H-105.988 Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices

CSAPH Report 3 – Genome Editing and its Potential Clinical Use

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

1. That our American Medical Association (AMA) encourage continued research into the therapeutic use of genome editing.

2. That our AMA urge continued development of consensus international principles, grounded in science and ethics, to determine permissible therapeutic applications of germline genome editing.

MSS Position: **Support**

MSS Policy Justifying Position: 460.004MSS Human Genome Project; formal support for H-440.911 Medicine/Public Health Initiative

CSAPH Report 4 – Hormone Therapies: Off-Label Uses and Unapproved Formulations

The Council on Science and Public Health recommends the following recommendations be adopted in lieu of Resolution 512-A-15 and the remainder of the report be filed:

1. That Policy D-120.969 be amended by addition and deletion to read as follows:

D-120.969 FDA Oversight of Bioidentical Compounded Hormone (BH) Therapy Preparations

Our AMA will: (1) recognizes the term “bioidentical hormone” as a marketing term not grounded in science; use of the term “compounded hormone therapy” is preferred; (12) will urge that renewed attention be devoted to the of the Food and Drug Administration (FDA) to conduct surveys for purity and potency dosage accuracy of all compounded hormone therapy “bioidentical hormone” formulations; (23) will urge continued attention to the FDA to require mandatory reporting by drug manufacturers, including compounding pharmacies, of adverse events related to the use of compounded hormone therapies “bioidentical hormones”; (3) urge the FDA to create a registry of adverse events related to the use of compounded “bioidentical hormone” preparations; (4) recommends that physicians and other prescribers fully inform patients of the potential side effects and risks of the use of compounded hormone replacement therapy; and (5) will request that when drug ingredients with black box warnings are used in compounded products, patients should be informed about the FDA require the inclusion of uniform patient information, such as warnings and precautions associated with the use of such drug ingredients, in packaging of compounded “bioidentical hormone” products; and (5) urge the FDA to prohibit the use of the term “bioidentical hormones” unless the preparation has been approved by the FDA.

2. Our AMA supports that patients be informed that compounded products are not FDA-approved.

3. That our AMA urge the United States Pharmacopeia to re-examine the validity of the current estriol monograph.

MSS Position: **Support**

MSS Policy Justifying Position: 460.012MSS Encouraging Research Into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients; 100.001MSS Ethical Concerns and Development of New Medications

902 – Removing Restrictions on Federal Public Health Crisis Research

RESOLVED, That our American Medical Association recognize the importance of timely research and open discourse in combatting public health crises; and be it further

RESOLVED, That our AMA oppose efforts to restrict funding or suppress the findings of biomedical and public health research for the purpose of influencing political discourse.

MSS Position: **Support**

MSS Policy Justifying Position: 460.018MSS Removing Restrictions on Federal Public Health Crisis Research (HOD resolution is MSS-authored)

903 – Prevention of Newborn Falls in Hospitals

RESOLVED, That our American Medical Association support implementation of newborn fall prevention plans and post-fall procedures through clinically proven, high-quality, and cost-effective approaches.

MSS Position: **Support**

MSS Policy Justifying Position: 215.005MSS Prevention of Newborn Falls in Hospitals (HOD resolution is MSS-authored)

904 – Improving Mental Health at Colleges and Universities for Undergraduates

RESOLVED, That our American Medical Association support accessibility and de-stigmatization as strategies in mental health measures implemented by colleges and universities, in order to improve the provision of care and increase its use by those in need; and be it further

RESOLVED, That our AMA support colleges and universities in publicizing the importance of mental health resources, with an emphasis on the availability and efficacy of such resources; and be it further

RESOLVED, That our AMA support collaborations of university mental health specialists and local health centers in order to provide a larger pool of resources, such that any student be able to access care in a timely and affordable manner.

MSS Position: **Support**

MSS Policy Justifying Position: 345.011MSS Improving Mental Health at Colleges and Universities for Undergraduates (HOD resolution is MSS-authored)

905 – Chronic Traumatic Encephalopathy (CTE) Awareness

RESOLVED, That our American Medical Association amend part one of H-470.954 by addition and deletion to read as follows:

Reduction of Sports-Related Injury and Concussion H-470.954:

1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; ~~and~~ (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences; and (c) promote education for physicians and the public on the detection, treatment and prognosis of chronic traumatic encephalopathy (CTE).; and be it further

RESOLVED, That our AMA work with interested agencies and organizations to advocate for further research into the causes of and treatments for chronic traumatic encephalopathy (CTE).

MSS Position: **Support**

MSS Policy Justifying Position: 470.007MSS Athlete Concussion Management and Chronic Traumatic Encephalopathy Prevention; 10.010MSS Return to Play After Suspected Concussion; 470.008MSS Encouraging the Research and Development of Concussion Tracking Technology in the Sport of Football

906 – Universal Color Scheme for Respiratory Inhalers

RESOLVED, That our American Medical Association work with leading respiratory inhaler manufacturing companies and health agencies such as the Federal Drug Administration and the American Pharmacists Association to develop consensus of a universal color scheme for short-acting beta-2 agonist respiratory inhalers that are used as “rescue inhalers” in the United States; and be it further

RESOLVED, That our AMA work with leading respiratory inhaler manufacturing companies to ensure the universal color scheme for respiratory inhalers would allow for the least disruption possible to current inhaler colors, taking into account distribution of each brand and impact on current users if color were to change; and be it further

RESOLVED, That our AMA work with leading respiratory inhaler manufacturing companies to ensure that universal color scheme for respiratory inhalers be designed for adherence and sustainability, including governance for future companies entering the respiratory inhaler market, and reserving colors for possible new drug classes in the future.

MSS Position: **Support**

MSS Policy Justifying Position: 115.002MSS Advocacy for a System of Improved and Standardized Instructions for Drug Labels in order to Promote Health Literacy and Patient Well-Being

907 – Clinical Implications and Policy Considerations of Cannabis Use

RESOLVED, That our American Medical Association amend policy H-95.998 by addition and deletion to read as follows:

AMA Policy Statement on Cannabis H-95.998:

Our AMA believes that (1) cannabis is a dangerous drug and as such is a public health concern; (2) ~~sale of cannabis should not be legalized;~~ (3) public health based strategies, rather than incarceration, should be utilized in the handling of individuals possessing cannabis for personal use; and (4) (3) additional research should be encouraged.; and be it further

RESOLVED, That our AMA to amend policy D-95.976 by deletion to read as follows:

Cannabis - Expanded AMA Advocacy D-95.976

1. Our AMA will educate the media and legislators as to the health effects of cannabis use as elucidated in CSAPH Report 2, I-13, A Contemporary View of National Drug Control Policy, and CSAPH Report 3, I-09, Use of Cannabis for Medicinal Purposes, and as additional scientific evidence becomes available.
2. Our AMA urges legislatures to delay initiating full legalization of any cannabis product until further research is completed on the public health, medical, economic and social consequences of use of cannabis and, instead, support the expansion of such research.
3. Our AMA will also increase its efforts to educate the press, legislators and the public regarding its policy position that stresses a "public health", as contrasted with a "criminal," approach to cannabis.
4. Our AMA shall encourage model legislation that would require placing the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. ~~It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States.~~"

MSS Position: **Support**

MSS Policy Justifying Position: **Caucus vote taken to support based on policy (simple majority);**
95.008MSS Cannabis and the Regulatory Void; 95.003MSS Marijuana: Medical Use and Research

908 – Faith and Mental Health

RESOLVED, That our American Medical Association advocate and support mental health and faith community partnerships that will provide a platform for faith leaders to get educated about psychiatric and substance abuse disorders and mental health providers understand the role of faith in recovery; and be it further

RESOLVED, That our AMA study and support a partnership to foster respectful, collaborative relationships between psychiatrists, other mental health providers and the faith-based community to improve quality care for individuals and families with mental health and substance abuse problems.

MSS Position: **Support**

MSS Policy Justifying Position: 65.021MSS Addressing Patient Spirituality in Medicine; 345.002MSS An Initiative to Encourage Mental Health Education in Public Schools and Reducing Stigma and Increasing Detection of Mental Illnesses; 200.018MSS Incorporating Community Health Workers into the U.S. Health Care System; formal support for D-345.994 Increasing Detection of Mental Illness and Encouraging Education

909 – Promoting Retrospective and Cohort Studies on Pregnant Women and Their Children

RESOLVED, That our American Medical Association recommend to the US Department of Health and Human Services that the Federal Policy for the Protection of Human Subjects, or "Common Rule", be

updated to define pregnant women as “scientifically complex” rather than a “vulnerable population” for research purpose; and be it further

RESOLVED, That our AMA urge the federal government to prioritize clinical research and generation and dissemination of data, emphasizing retrospective and cohort studies, on common medications' effects on underlying medical conditions across the entire continuum from pregnancy through lactation and development to better inform prescribing; and be it further

RESOLVED, That our AMA support federal legislation to 1) establish an interagency taskforce within the Department of Health and Human Services to improve federal interagency and key stakeholder communication, coordination and collaboration to advance research on medications in pregnancy and breastfeeding, and 2) to require the United States Food and Drug Administration to provide regular reports to Congress tracking the inclusion of pregnant and breastfeeding women in clinical trials.

MSS Position: **Support Resolved 2**

MSS Policy Justifying Position: 525.006MSS Supporting the Inclusion of Pregnant Women in Research; 525.001MSS Inclusion of Women in Clinical Trials; 420.002MSS Substance Abuse During Pregnancy; 440.024MSS Advertising for Herbal Supplements

910 – Disparities in Public Education as a Crisis in Public Health and Civil Rights

RESOLVED That our American Medical Association consider continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; and be it further

RESOLVED That our AMA 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 as one of the great unmet health and civil rights challenges of the 21st century.

MSS Position: **Support**

MSS Policy Justifying Position: **Caucus vote taken to support (2/3)**; 295.181MSS Providing Greater Emphasis on the Social Determinants of Health in Medical School Curriculum; 350.011MSS Continued Support for Diversity in Medical Education; formal support for D-60.988 Early Childhood and Family Education as a Mechanism to Advance Family Health; formal support for H-350.979 Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession; formal support for H-170.985 Science, Technology, Engineering and Mathematics Education; formal support for D-200.985 Strategies for Enhancing Diversity in the Physician Workforce; formal support for H-350.978 Minorities in the Health Professions

911 – Importance of Oral Health in Medical Practice

RESOLVED, That our American Medical Association recognize the importance of managing oral health as a part of overall patient care; and be it further

RESOLVED, That our AMA support efforts to educate physicians on oral condition screening and management, as well as the consequences of poor oral hygiene on mental and physical health; and be it further

RESOLVED, That our AMA encourage closer collaboration of physicians with dental providers to provide comprehensive medical care; and be it further

RESOLVED, That the AMA support efforts to increase access to oral health services.

MSS Position: **Support**

MSS Policy Justifying Position: 440.058MSS Importance of Oral Health in Medical Practice

913 – Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems

RESOLVED, That our American Medical Association support efforts to assess the usage of genetic testing and need for counseling services, physician preparedness in counseling patients or referring them to board-certified genetics specialists; and be it further

RESOLVED, That our AMA encourage efforts to create and disseminate guidelines for best practice standards concerning counseling for genetic test results; and be it further

RESOLVED, That our AMA support further research into and open discourse concerning issues in medical genetics, including the genetic specialist workforce shortage, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic test results and counseling on patient satisfaction.

MSS Position: **Support**

MSS Policy Justifying Position: 200.019MSS Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems (HOD resolution is MSS-authored)

917 – Youth Incarceration in Adult Prisons

RESOLVED, That our American Medical Association oppose incarceration of children (individuals less than 18 years of age) in adult prisons for non-violent crimes; and be it further

RESOLVED, That our AMA work with appropriate organizations to address age cutoffs for children (individuals less than 18 years of age) in adult prisons; and be it further

RESOLVED, That our AMA advocate for elimination of the incarceration of children (individuals less than 18 years of age) in adult prisons for non-violent crimes; and be it further

RESOLVED, That our AMA advocate for the passage of legislation that addresses reform for children (individuals less than 18 years of age) in adult prisons with respect to developing appropriate guidelines for parole, expungement and sealing of records, and solitary confinement; and be it further

RESOLVED, That our AMA support early intervention and rehabilitation for children (individuals 18 years of age or younger) that have been incarcerated in adult prisons.

MSS Position: **Support**

MSS Policy Justifying Position: **Caucus vote taken to support (2/3)**; 140.028MSS Solitary Confinement; 270.029MSS AMA Support for Justice Reinvestment Initiatives; 345.008MSS Improving the Intersection Between Law Enforcement and the Mentally Ill

921 – Raise the Minimum Age of Legal Access to Tobacco to 21 Years

RESOLVED: That our American Medical Association reaffirm its support for raising the minimum age of legal access to tobacco products to 21 years.

MSS Position: **Support**

MSS Policy Justifying Position: 505.009MSS Community Enforcement of Restrictions on Adolescent Tobacco Use; 490.024MSS Banning Smoking While Driving in Vehicles in which Minors are Present; formal support for H-495.985 Smokeless Tobacco

922 – Responsible Parenting and Access to Family Planning

RESOLVED, That our American Medical Association reaffirm its commitment to work with all of the national medical societies and other interested organizations involved in women's health care to ensure the education of women on the proper use of Food and Drug Administration-approved methods of family planning and assure that reproductive counseling is accessible and appropriately funded.

MSS Position: **Support**

MSS Policy Justifying Position: 75.009MSS Ending Discrimination Against Contraception; 310.048MSS Training in Reproductive Health Topics as a Requirement for Accreditation of Family Medicine Residencies; 75.003MSS Contraceptive Programming in the Media; 75.011MSS Informed Consent with Regards to Advertising and Prescribing Contraceptives; 75.012MSS Recognizing Long-Acting Reversible Contraceptives (LARCs) as Efficacious and Economical Forms of Contraception; 170.010MSS Abstinence-Only Education and Federally-Funded Community-Based Initiatives; formal support for H-170.968 Sexuality Education, Abstinence, and Distribution of Condoms in Schools

924 – AMA Advocacy for Environmental Sustainability and Climate

RESOLVED, That our American Medical Association develop a strategy to advocate for governments and other organizations to promote environmental sustainability and other efforts to halt global climate change; and be it further

RESOLVED, That our AMA incorporate principles of environmental sustainability within its institutional mission and business operations; and be it further

RESOLVED, That our AMA offer programs to physicians to assist them to adopt environmental sustainability in their practices and to help physicians to share these concepts with their patients and with their communities.

MSS Position: **Support**

MSS Policy Justifying Position: 135.012MSS Toward Environmental Responsibility; 135.002MSS Environmental Protection; 135.003MSS Recycling in the Medical Community; 135.005MSS Promotion of Conservation Practices within the AMA; 135.006MSS Recycling; 135.013MSS Statement of Sustainability Principles; formal support for H-135.939 Green Initiatives and the Health Care Community

925 – Graphic Warning Label on all Cigarette Packages

RESOLVED, That our American Medical Association evaluate all opportunities for effective advocacy by organized medicine to require graphic warning labels depicting the dangers of smoking on all cigarette packages; and be it further

RESOLVED, That our AMA endorse efforts of the Campaign for Tobacco Free Kids and the Food and Drug Administration to require tobacco companies to include graphic warning labels depicting the dangers of smoking on all cigarette packages.

MSS Position: **Support**

MSS Policy Justifying Position: 500.004MSS Picture-Based Warnings on Tobacco Products; 490.005MSS "Smoke Free" Educational; formal support for H-490.917 Physician Responsibilities for Tobacco Cessation; formal support for H-495.985 Smokeless Tobacco

926 – Establishing and Achieving National Goals to Eliminate Lead Poisoning and Prevent Lead Exposures to Children

RESOLVED, That our American Medical Association call on the United States government to establish national goals to:

- a) Ensure that no child has a blood lead level $>5 \mu\text{g/dL}$ ($>50 \text{ ppb}$) by 2021, and
- b) Eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level $> 1 \mu\text{g/dL}$ (10 ppb); and

RESOLVED, That our AMA work with the United States government in all its agencies to pursue the following strategies to achieve this goal:

- a) Adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment,
- b) Identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed,

- c) Continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services,
- d) Eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions;
- e) Provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and,
- f) Establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above 1 µg/dL (10 ppb).

MSS Position: **Support**

MSS Policy Justifying Position: 440.057MSS Improving Detection, Awareness, and Prevention of Lead Contamination in Water; 440.007MSS Lead Based Paints



MSS Summary of Fiscal Notes (A-17)

Minimal – less than \$1,000
Modest – between \$1,000 - \$5,000
Moderate – between \$5,001-\$10,000
Significant – greater than \$10,000

<u>Resolutions</u>	<u>Fiscal note</u>
01 – Protection of Transgender Individuals’ Right to Use Public Facilities in Accordance with Their Gender Identity	Minimal
02 – Increasing the Threshold for Extraction from the Reaffirmation Calendar	Minimal
03 – Expanding Expedited Partner Therapy to Treat Trichomoniasis	Minimal
04 – Public Access To Chargemasters	Minimal
05 – The Diaper Gap	Modest
06 – Improving Appropriate Language Access and Use of Interpreters in Healthcare Settings	R1, R2, R3: Modest R4: Minimal
07 – Opioid Abuse in Breastfeeding Mothers	Moderate
08 – Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis	Moderate
09 – Defending Federal Child Nutrition Programs	Modest



10 – Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals	R1, R2, R3: Moderate; R4, R5: Minimal
11 – Co-location of Behavioral Health Care and Primary Care	Minimal
12 – National Healthcare Finance Reform: Single Payer Solution	Minimal
13 – Reproductive Health Care in Religiously-Affiliated Hospitals	Minimal
14 – Educating Physicians About the Importance of Cervical Cancer Screening for Female-to-Male Transgender Patients	Minimal
15 – Patient and Physician Rights Regarding Immigration Status	Modest
16 – Air Ambulance Regulations and Reimbursements	Moderate
17 – Addressing Foster Care Healthcare Needs	Moderate
18 – Amendment of AMA-MSS Cannabis Policy	Minimal
19 – Human Rights as the Foundation of Public Health	Minimal
20 – Decreasing Screen Time and Increasing Outdoor Activity to Offset Myopia Onset and Progression in Elementary School Children	Minimal
21 – Sexual Assault Survivors’ Rights	Moderate
22 – Improving Medical Care in Immigrant Detention Centers	Modest



23 – Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability	Modest
24 – Opposing Physician Participation in Court-Initiated Castration	Minimal
25 – Economic Sustainability and Improved Usage of Health Information Exchanges	Minimal
26 – Increase Access to HIV PrEP for At-Risk Individuals	R1, R2: Minimal R3: Moderate
27 – Disaggregation of Data Concerning the Status of Asian-Americans	Modest
28 – Reducing Nicotine Content In Cigarettes	Modest
29 – Opposition to Medicaid Work Requirements	Minimal
30 – Federal Agricultural Subsidy Reform	Minimal
31 – Investigating the Diagnosis of Post-Lyme Disease Syndrome and Determining the Validity of Alternative Therapies	Modest
32 – Protecting the Integrity of Phase III Clinical Trials	Minimal
33 – AMA Policy on Investing in the Fossil Fuel Industry	Modest
34 – Opposition to Capital Punishment	Minimal
35 – Research, Education and Awareness Regarding Non-Opioid Pain Management Treatments	Moderate
36 – Insurance Coverage of Skin Care Products in The Treatment of Chronic Skin Disorders	Minimal



37 – Recognizing Poverty-Level Wages as a Social Determinant of Health	Minimal
38 – Preventing Resident Physician Suicide	Modest
39 – Impact of Detracting Patient Autonomy in Eating Disorder Treatment	Moderate
40 – Addressing Burnout in Medical Education Faculty	Modest
41 – Addressing Social Media Usage and its Negative Impacts on Mental Health	Modest
42 – Redistribution of Unused Prescription Drugs to Pharmaceutical Donation and Reuse Programs	Modest
43 – Increased Use of Body-Worn Cameras by Law Enforcement Officers	Modest
44 – Patient Safety During Handoffs and Transfers of Care	Modest
45 – Collecting and Releasing Data on Law Enforcement Use of Force	Modest
46 – Identifying and Addressing Food Insecurity and Food Deserts Nationwide	R1, R2: Moderate R3: Minimal
47 – Improving Recognition and Diagnosis of Fragile-X Diseases	Modest
48 – Promoting Education on How to Evaluate Asylum Seekers for Signs of Physical and/or Psychological Torture	Modest
49 – Culturally-Competent Preventative Care for Immigrant Populations	Minimal
50 – Opposition to Abuses of the Orphan Drug Act	Modest
51 – Expanding GME Funding Sources	Moderate



Reports

CME Report A – Redefining Policy for Resident Duty-Hours Based on New Evidence, With A Focus on Addressing Resident Wellness	Minimal
COLRP Report A – Reevaluation of AMA-MSS Region Bylaws	Minimal
GC Report A – Biennial Review of Organizations Seated in the AMA-MSS Assembly	Minimal
GC Report B – Review of AMA-MSS Statements of Support for HOD Policies	Minimal
GC Report C – Updates to the MSS Internal Operating Procedures	Minimal

Medical Student National Service Project



MEDICINE TAKE BACK DAY

Saturday, June 10 • 9 am – 12 pm

Metropolitan Water Reclamation District HQ
100 E. Erie St.
Chicago, IL 60611

#AMAmtg #AMAZingA17





MEDICATION TAKE-BACK

The American Medical Association and the Metropolitan Water Reclamation District of Greater Chicago

June 10, 2017 from 9 a.m. to 12 p.m.

Bring your old medications to

The Metropolitan Water Reclamation District of Greater Chicago Headquarter Building located at

100 East Erie Street

Tips for Medication Drop-Off:

Here are some instructions to follow to make sure your stop goes smoothly.

- Unless otherwise specified, use original prescription containers and use permanent marker to **mark out your name and personal information.**
- Please follow direction at the drop-off site carefully. **Only give medications to personnel at the drop-off site.**
- **This is NOT a share or reuse opportunity.** All medications received will be destroyed in an environmentally responsible manner.

Please be aware that the following items will NOT be accepted:

- Illegal drugs
- Liquid containers more than 4 ounces
- Sharps containers, needles, or syringes
- Batteries
- Aerosol spray cans
- Medical devices, chemicals or other hazardous materials



Is your medicine cabinet full of expired drugs or medications you no longer use? Now is the time to get rid of them!

Benefits to Proper Drug Disposal

- Prevents poisoning of children and pets
- Deters misuse by teenagers and adults
- Avoids health problems from accidentally taking the wrong medicine, too much of the same medicine, or a medicine that is too old to work well
- Keeps medicines from entering streams and rivers when poured down the drain or flushed down the toilet

Looking to do your part in protecting our waterways? Help keep our drains drug free!



Plan to attend!

2017 AMA Women Physicians Section Annual Meeting

Saturday, June 10
Hyatt Regency Chicago

**CME
AVAILABLE!**

The American Medical Association Women Physicians Section (AMA-WPS) Annual Meeting offers a unique opportunity to network with physicians from across the country and meet leaders from state societies, specialty societies and the AMA. Please plan to attend.

8:30–10 a.m.

Responding to the impact of the opioid epidemic on women

Approved for 1.5 AMA PRA Category 1 Credits™*
Columbus I/J room

Moderator: Claudia Reardon, MD, Associate Professor, University of Wisconsin School of Medicine

Speakers:

- Melinda Campopiano, MD, Chief Medical Officer, Substance Abuse and Mental Health Services Administration
- Mishka Terplan, MD, MPH, FACOG, FASAM, Professor, Virginia Commonwealth University
- Mary Anne McCaffree, MD, Professor of Pediatrics, University of Oklahoma College of Medicine
- Patrice Harris, MD, Chair, AMA Board of Trustees

Program description:

Attendees will learn to: differentiate between variables that increase the risk of addiction to prescription opioids in women; describe trends related to opioid prescribing, opioid use disorder, and unintentional overdose among adolescent girls and women; and identify ways to effectively manage pain and reduce opioid-related harm.

5:30–7:30 p.m.

Business meeting and reception

Columbus E/F room

The meeting will feature dynamic presentations and a review of the AMA House of Delegates Handbook.

Monday, June 12

Columbus H room

11:30 a.m. – 1 p.m.

AMA-WPS Associates lunch and business meeting

Participants will discuss current and emerging issues impacting the professional lives of women physicians and women's health issues. The discussion will also include details on Women in Medicine Month, taking place in September.

*The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The American Medical Association designates this live activity for a maximum of 1.5 AMA PRA Category Credits™. Physicians should claim only the credit commensurate with the extent of their participation in this activity.

2017 Annual Meeting of the AMA Advisory Committee on LGBTQ Issues

Transgender health and social justice

Room: Plaza B
5:30–7 p.m. | Friday, June 9
Reception and caucus

Magda Houlberg, MD
Howard Brown Health of Chicago



Health equity and the intersectionality of minority and LGBTQ health

Room: Randolph 3
10 a.m.–noon | Saturday, June 10

Session 1 (10–11 a.m.)

Moderator
Carl G. Streed Jr., MD
AMA Advisory Committee on LGBTQ Issues

Panelists
Abbas Hyderi, MD, MPH
University of Illinois at Chicago College of Medicine

David Ernesto Munar
Howard Brown Health

Mona Norlega, MBA, MPA
Chicago Commission on Human Relations

Session 2 (11 a.m.–noon)

Moderator
Frank A. Clark, MD
Governing Council, AMA-MAS

Panelists
Maxx Boykin
AIDS Foundation of Chicago

Kim Hunt
Pride Action Tank

Julie Morita, MD, MPH
Chicago Department of Public Health

Co-sponsors

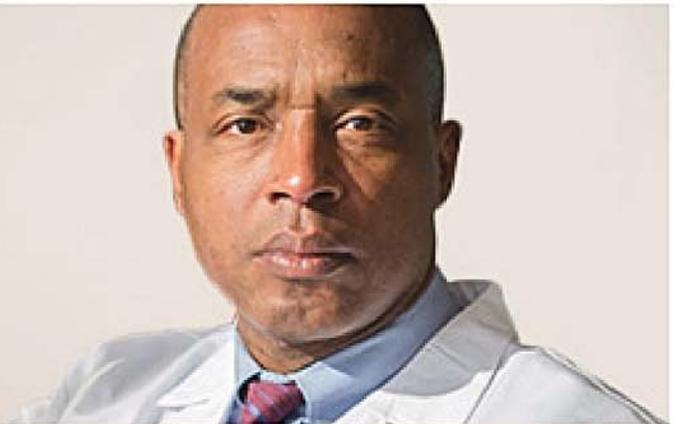
AMA Advisory Committee on LGBTQ Issues
AMA Medical Student Section Minority Issues Committee
AMA Minority Affairs Section (MAS)

2017 AMA Minority Affairs Section Annual Meeting

Addressing intentional violence through a public health lens

Room: Columbus K/L
4:30–6 p.m. | Friday, June 9
Reception and business meeting

Selwyn Rogers, MD, MPH
University of Chicago Medicine Trauma Center



Health equity and the intersectionality of minority and LGBTQ health

Room: Randolph 3
10 a.m.–noon | Saturday, June 10

Session 1 (10–11 a.m.)

Moderator
Carl G. Streed Jr., MD
AMA Advisory Committee on LGBTQ Issues

Panelists
Abbas Hyderi, MD, MPH
University of Illinois at Chicago College of Medicine

David Ernesto Munar
Howard Brown Health

Mona Noriega, MBA, MPA
Chicago Commission on Human Relations

Session 2 (11 a.m.–noon)

Moderator
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Governing Council, AMA-MAS

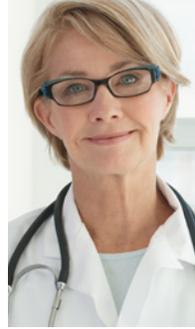
Panelists
Maxx Boykin
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Kim Hunt
Pride Action Tank

Julie Morita, MD, MPH
Chicago Department of Public Health

Co-sponsors

AMA Minority Affairs Section
AMA Advisory Committee on LGBTQ Issues
AMA Medical Student Section Minority Issues Committee



Plan to attend!

2017 AMA Senior Physicians Section Annual Meeting

Saturday, June 10
Hyatt Regency
Chicago
Columbus K/L

CME
AVAILABLE!

The American Medical Association Senior Physicians Section (SPS) invites you to our assembly and educational program held in conjunction with the 2017 AMA Annual Meeting. We hope you can join us and enjoy the fellowship of your senior physician colleagues.

Noon–1:30 p.m.

Mindfulness interventions: A workshop to foster resiliency

Approved for 1.5 AMA PRA Category 1 Credits™*

Introduced by: Claire V. Wolfe, MD, AMA-SPS Governing Council

Speaker: Philip Cass, PhD, consultant, TLP Group Inc., Columbus, Ohio

Moderator: Paul H. Wick, MD, chair-elect, AMA-SPS Governing Council

Program description

Mindfulness—the process of bringing one’s attention to internal and external experiences occurring in the present moment—can be developed through the practice of meditation. Recent research has indicated a correlation between mindfulness and improved well-being, suggesting mindfulness can even help alleviate many mental and physical conditions. This session will explore how incorporating mindfulness interventions into your daily life can be effective in developing a healthy state of active and open attention to the present.

Objectives

- Review the latest understanding of the effects that mindfulness meditation has on the brain.
- Assess the implications mindfulness meditation has for physicians in their practice of medicine.
- Evaluate how to incorporate mindfulness techniques in daily life.
- Practice three easy-to-implement mindfulness techniques.

Assembly meeting

The AMA–SPS extends an open invitation to all physicians 65 years of age and above to attend our business meeting right before the mindfulness workshop. The AMA-SPS will discuss AMA House of Delegates’ business items and future AMA-SPS activities.

A light lunch will be offered at 11:30 a.m. – first come, first served!

Visit ama-assn.org/senior-physicians-section to learn more.

*The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The American Medical Association designates this live activity for a maximum of 1.5 AMA PRA Category Credits™. Physicians should claim only the credit commensurate with the extent of their participation in this activity.

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AMA-APS Annual Meeting

June 9–10
Hyatt Regency Chicago
Chicago

All academic physicians and medical education leaders are invited to attend the 2017 American Medical Association Academic Physicians Section (APS) Annual Meeting.

AMA-APS business meeting

First session

12:30 p.m. | June 9 | Columbus I–J

(optional orientation for new members at 11:30 a.m.)

The agenda includes:

- Progress of the AMA's Accelerating Change in Medical Education Consortium
- Update from the Accreditation Council for Graduate Medical Education
- Table discussions on best practices for improving your institution's impact/involvement in organized medicine and the AMA
- The AMA's GME Competency Education Program (module demo)

Welcome presentation: Diane B. Wayne, MD, vice dean, education, Feinberg School of Medicine, Northwestern University

Second session

7:30 a.m. | June 10 | Columbus C–D

Review medical education-related reports and resolutions to go before the AMA House of Delegates. In addition, AMA-APS members will elect the members of the 2017–2018 AMA-APS Governing Council.

AMA-APS educational sessions

Apps for academic physicians: The hows and whys
9 a.m. | June 10 | Columbus C–D

Co-sponsors: AMA International Medical Graduates (IMG) Section, AMA Senior Physicians Section

Consider the development of innovations in medical education, as well as apps and tools for academic physicians to help them better prepare students and residents to practice in a changing health care environment. Also, learn ways to integrate patient apps and data resulting from these apps into practices to improve patient care, compliance and communication. Featured presenters: George Mejicano, MD, AMA-APS chair-elect; Michael Hodgkins, MD, MPH, chief medical information officer, AMA; A.L. Jones, MD, MS, AMA Young Physicians Section member and AMA-HOD delegate, American College of Occupational and Environmental Medicine; and Arjun Gupta, medical student member, 2017–2018 AMA Council on Medical Education

Approved for 1.25 AMA PRA Category 1 Credits™.

Funding for accountability, sustainability and transparency in medical education: A proposed model for meeting physician workforce needs

10:30 a.m. | June 10 | Columbus C–D

Co-sponsor: AMA-IMG Section

Kelly Caverzagie, MD, associate dean, educational strategy, University of Nebraska College of Medicine, will outline the details of this model and describe its potential implications for availability of GME slots, meeting service needs of current patients and addressing future workforce needs.

Approved for 1.25 AMA PRA Category 1 Credits™.

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The American Medical Association designates these educational activities for a maximum of 2.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activities.

Visit ama-assn.org/aps-annual-meeting to learn more.