Medical Student Section Agenda

Registration 3:00–8:00pm | Regency Ballroom Foyer

Thursday, June 7

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:00-4:30pm</td>
<td>Annual meeting orientation</td>
<td>Regency A-C</td>
</tr>
<tr>
<td>4:30-5:30pm</td>
<td>Candidate forum*</td>
<td>Regency A-C</td>
</tr>
<tr>
<td>4:30-5:30pm</td>
<td>Student delegate credentialing</td>
<td>Outside Regency A-C</td>
</tr>
<tr>
<td>5:30-7:00pm</td>
<td>Opening assembly&lt;br&gt;MSS Chair address, Board of Trustees update, Washington Brief, Member Experience update, nominations*, extractions*</td>
<td>Regency A-C</td>
</tr>
<tr>
<td>7:00-9:00pm</td>
<td>AMA-MSS Region Business Meetings&lt;br&gt;Region 1: Acapulco</td>
<td>Region 2: Hong Kong</td>
</tr>
</tbody>
</table>

*Take note

Region 1<br>Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington (WWAMI), Wyoming

Region 2<br>Illinois, Iowa, Minnesota, Missouri, Nebraska, Wisconsin

Region 3<br>Arkansas, Kansas, Louisiana, Mississippi, Oklahoma, Texas

Region 4<br>Alabama, Florida, Georgia, North Carolina, Puerto Rico, South Carolina, Tennessee

Region 5<br>Indiana, Kentucky, Michigan, Ohio, West Virginia

Region 6<br>Delaware, District of Columbia, New Jersey, Maryland, Pennsylvania, Virginia

Region 7<br>Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont
### Friday, June 8

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00-8:00am</td>
<td>Student delegate credentialing</td>
<td>Outside Regency A-C</td>
</tr>
<tr>
<td>8:00-9:30am</td>
<td>Business meeting Candidate speeches, vote on acceptance of business</td>
<td>Regency A-C</td>
</tr>
<tr>
<td>9:30-11:30am</td>
<td><strong>AMA-MSS Region Business Meetings</strong></td>
<td>Regency A-C</td>
</tr>
<tr>
<td>Region 1: Hong Kong</td>
<td>Region 2: Wrigley</td>
<td>Region 3: Grand Ballroom B</td>
</tr>
<tr>
<td>10:00-11:00am</td>
<td>Exploring the cutting edge of gene therapy in medicine</td>
<td>Acapulco</td>
</tr>
<tr>
<td>11:00am-12:00pm</td>
<td>A day in the life of me: Tackling prejudice against providers</td>
<td>Acapulco</td>
</tr>
<tr>
<td>Guest Panelists: Omar Salman, Chair, AMA MSS Committee on LGBTQ Issues</td>
<td>Sam Dubin, member, AMA MSS Committee on LGBTQ Issues</td>
<td>Sohayla Rostami, DO, Vice Chair, AMA MSS Committee on Global and Public Health</td>
</tr>
<tr>
<td>12:00-1:00pm</td>
<td>Medical Student Outreach Program (MSOP) training</td>
<td>Acapulco</td>
</tr>
<tr>
<td>12:30-1:00pm</td>
<td>Student delegate credentialing</td>
<td>Regency A-C</td>
</tr>
<tr>
<td>1:00-5:00pm</td>
<td>Business meeting AMA President address, AMA ACE update</td>
<td>Regency A-C</td>
</tr>
<tr>
<td>1:30-2:30pm</td>
<td>After the smoke clears: Provider well-being after mass casualty incidents</td>
<td>Acapulco</td>
</tr>
<tr>
<td>Guest Speakers: Dr. Michael Karch, MD, FAAOS</td>
<td>AMA-MSS Committee on Global and Public Health</td>
<td></td>
</tr>
<tr>
<td>3:00-4:00pm</td>
<td>Law and medicine: Embracing the gray</td>
<td>Acapulco</td>
</tr>
<tr>
<td>Guest Speakers: Leonard Nelson, JD, Director, AMA Litigation Center</td>
<td>Erin Sutton, JD, LLM, Associate Counsel, AMA Litigation Center</td>
<td></td>
</tr>
<tr>
<td>Moderators: Raisa Tikhtman &amp; Neha Anand, Vice chair and member of AMA-MSS Committee on Legislation and Advocacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:30-5:30pm</td>
<td>Meet and greet your MSS standing committees</td>
<td>Acapulco</td>
</tr>
<tr>
<td>6:00-8:00pm</td>
<td><strong>AMA-MSS Region Business Meetings</strong></td>
<td>Regency A-C</td>
</tr>
<tr>
<td>Region 1: Acapulco</td>
<td>Region 2: Hong Kong</td>
<td>Region 3: Gold Coast</td>
</tr>
<tr>
<td>8:00-8:30pm</td>
<td>Newly-elected Region leadership orientation</td>
<td>Regency A-C</td>
</tr>
</tbody>
</table>

### Saturday, June 9

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:30-7:00am</td>
<td>Student delegate credentialing</td>
<td>Regency A-C</td>
</tr>
<tr>
<td>Begin at 7:30am</td>
<td>MSS GC elections</td>
<td>Regency A-C</td>
</tr>
<tr>
<td>8:00-10:00am</td>
<td>Business meeting</td>
<td>Regency A-C</td>
</tr>
<tr>
<td>8:30-9:30am</td>
<td>Improving health outcomes for vulnerable patient populations</td>
<td>Crystal Ballroom B</td>
</tr>
<tr>
<td>9:45-10:45am</td>
<td>#MeToo: Sexual harassment and discrimination in medicine</td>
<td>Crystal Ballroom B</td>
</tr>
<tr>
<td>10:45am-12:00pm</td>
<td>From disruption to reform: Learn to spark change and move medicine forward</td>
<td>Columbus C-D</td>
</tr>
<tr>
<td>11:00am-12:00pm</td>
<td>Health care change agents: Traditional and non-traditional players fuel the fire</td>
<td>Crystal Ballroom C</td>
</tr>
<tr>
<td>11:00am-12:00pm</td>
<td>Small changes, big results: Innovations in patient-centered technology</td>
<td>Regency Ballroom A-C</td>
</tr>
<tr>
<td>11:30am-1:30pm</td>
<td><strong>AMA Medical Specialty Showcase &amp; Clinical Skills Workshop</strong></td>
<td>Riverside East Exhibit Hall</td>
</tr>
</tbody>
</table>
2018 AMA Medical Student Section Annual Meeting
Hyatt Regency Chicago, Illinois
June 7-9

Credentials Committee
GC Liaisons: Anna Yap, Speaker; Jay Llaniguez, Vice Speaker

Annah Baykal, Chair
Sophie Chung
Talal Alsheqaih
Arjun Watane
Nadia Sion
Allison Linehan
Amanda Whitehouse
Veronica Coleman

University of Oklahoma
Yale University School of Medicine
Wayne State University School of Medicine
University of Miami Leonard M. Miller School of Medicine
Central Michigan University College of Medicine
Medical College of Wisconsin
University of Massachusetts Medical School
University of Alabama School of Medicine

House Coordination Committee
GC Liaisons: Jerome Jeevarajan, Delegate; Kieran McAvoy, Alternate Delegate

Trevor Cline, Chair
Dan Pfeifle, Chair
Theodore Rader, Vice Chair
Kevin Stephenoff, Vice Chair
Krish Nair
Rebecca Haines
Alexandria Wellman
Akul Yajnik
Madhulika Banerjee
Meghan Lark
Zoe Teton
Eric Xie
Allison Linehan
Lauren Engel
Nicholas Yeisley
Dana Benyas
Warren Stopak

University of California Davis School of Medicine
University of South Dakota School of Medicine
University of Toledo College of Medicine
University of Toledo College of Medicine
Northeast Ohio Medical University
Texas A&M University College of Medicine
Southern Illinois University School of Medicine
University of Toledo College of Medicine
University of Arizona College of Medicine - Tucson
University of Toledo College of Medicine
Oregon Health & Science University School of Medicine
Johns Hopkins University School of Medicine
Medical College of Wisconsin
Medical College of Wisconsin
University of Missouri - Kansas City School of Medicine
Wayne State University School of Medicine
Touro University College of Medicine

Hospitality Committee
GC Liaison: Kelly Landeen, At-Large Officer

Abra Shen, Chair
Rajalakshmy Arakoni
Neil Horsley

Harvard Medical School
Northeast Ohio Medical University
University of Kentucky College of Medicine
Logistics Committee
GC Liaisons: Anna Yap, Speaker; Jay Llaniguez, Vice Speaker; Karen Dionesotes, Vice Chair

Emily Benton, Chair  Jacobs School of Medicine at University of Buffalo
Nithin Edara  Loyola University of Chicago Stritch School of Medicine
Nicholas Yeisley  University of Missouri – Kansas City School of Medicine
Samantha Lund  Washington University in St. Louis School of Medicine
Mahbod Pourriahi  University of Toledo College of Medicine
Kevin Tang  Warren Alpert Medical School

Parliamentary Procedure Committee
GC Liaison: Karen Dionesotes, Vice Chair

Nathan Carpenter, Chair  Medical College of Wisconsin
Savannah Johnson  University of Alabama School of Medicine
Manasa Melachuri  Northeast Ohio Medical University
Harshitha Dudipala  Northeast Ohio Medical University
Michael Nitz  Boston University School of Medicine

Reference Committee
GC Liaisons: Anna Yap, Speaker; Jay Llaniguez, Vice Speaker

Celeste Peay, Chair  Boston University School of Medicine
Sophia Yang, Vice Chair  University of California, Irvine College of Medicine
Rowena Hann  Touro University California College of Osteopathic Medicine
Aleesha Shaik  Drexel University College of Medicine
Usman Aslam  New York Institute of Technology College of Osteopathic Medicine
Moudi Hubeishy  Jacobs School of Medicine at University of Buffalo
Stephanie Strohbeen  Medical College of Wisconsin – Central Wisconsin

Rules Committee
GC Liaisons: Anna Yap, Speaker; Jay Llaniguez, Vice Speaker; Helene Nepomuceno, Chair

Lauren Engel, Chair  Medical College of Wisconsin
Kristhna Kinariwala  Virginia Commonwealth University School of Medicine
Matthew Christensen  Chicago Medical School at Rosalind Franklin University
Bigyan Mainali  University of Alabama School of Medicine
2018 AMA Medical Student Section Annual Meeting
Hyatt Regency Chicago, Illinois
June 7-9

Descriptions of MSS educational programs

Thursday, June 7

MSS Annual Meeting Orientation
3:00-4:30pm | Regency A-C
Learn about everything the AMA Medical Student Section 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: Anna Yap, MD AMA-MSS Speaker | Jay Llaniguez, MD, MS, AMA-MSS Vice Speaker

Friday, June 8

Exploring the cutting edge of gene therapy in medicine
10:00-11:00am | Acapulco
Hosted by your MSS Committee on Scientific Issues
Gene therapy, especially germline gene editing in humans, is a controversial issue that will become a widespread reality in the field of medicine. The AMA is at the forefront of providing ethical boundaries and practice recommendations for use of these technologies in medicine. Current AMA policies address stem cell and genetics research but do not address the use of genetic therapies, such as emerging technologies like CRISPR-Cas9. This informational session will explore the topic of gene therapy and initiate a discussion of the important scientific and ethical considerations when using this technology for therapeutic purpose.

A day in the life of me: Tackling prejudice against providers
Hosted by your MSS Committee on LGBTQ Issues and MSS Committee on Global and Public Health
11:00am–12:00pm | Acapulco
While patients have the right to refuse care, sometimes a patient’s refusal of care may be based on overt or implicit bias against a physician. Institutional frameworks to address bias against physicians have arisen, but few healthcare centers have dedicated models to report and address these instances of discrimination, leaving its physicians and trainees vulnerable and unsupported. This session aims to shed light on patient and institutional bias against providers by exploring its prevalence in medicine, identifying what groups are most likely to face discrimination, and highlighting the need for awareness. Through a panel of individuals with
various backgrounds, we will explore their perspectives and attendees will come away with a greater understanding of the many forms of prejudice.

**After the smoke clears: Provider well-being after mass casualty incidents**
*Hosted by your MSS Committee on Global and Public Health*
1:30–2:30pm | Acapulco
During any major traumatic event or mass casualty incident, the medical providers take the responsibility of patient care despite the severity of the situation. In the midst of chaos, the providers are focused on care. In the aftermath, the spotlight remains on the victims and the community, often overlooking the medical providers. However, many providers experience PTSD, anxiety, depression, and other psychological reactions that are not addressed after the trauma of the experience. During this session, we hope to discuss provider care and wellbeing when traumatic events occur. Ultimately, we aim to address: how do we care for providers who care for our communities during the most difficult of times?

Guest speaker: Dr. Michael Karch, MD, FAAOS | AMA-MSS Committee on Global and Public Health

**Law and medicine: Embracing the gray**
*Hosted by your MSS Committee on Legislation and Advocacy*
3:00–4:00pm | Acapulco
During the first portion of this program, attendees will engage in a question and answer session with the authors of the AMA amicus brief on *NIFLA v. Becerra*, touching on areas of free speech, the California FACT Act, background of this lawsuit, the levels of scrutiny positions advocated by the parties’ briefs, and the impact the Supreme Court’s decision will have on patient care. The second portion of the program will introduce to attendees the efforts the AMA is taking to protect DACA enrollees.

Guest speakers: Leonard Nelson, JD Director, AMA Litigation Center; Erin Sutton, JD, LLM, Associate Counsel, AMA Litigation Center

**Meet ‘n’ greet your MSS Standing Committees**
*A MA-MSS Committee on Global and Public Health*
4:30-5:30pm | Acapulco
Are you interested in specific topics in medicine, such as global & public health? How about health information technology or medical education? You’re sure to find something that interests you in our 13 different Medical Student Section standing committees. Come to this session to network and learn how to apply to serve on a committee while committee member panelists present their role and the past projects of their committees.

**Saturday, June 9**

**AMA Medical Specialty Showcase & Clinical Skills Workshop**
11:30am–1:30pm | Riverside Exhibit Hall
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. Your MSS Committee on Long-Range Planning will be providing attendees with tools and resources for combatting burnout using our AMA Steps Forward modules.
## 2018 AMA Annual Meeting educational programming

**Friday, June 8**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Time</th>
<th>Location</th>
<th>Description</th>
<th>Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Value-based care: Understanding models of risk</strong></td>
<td>9 a.m.–noon</td>
<td>Crystal A</td>
<td>Learn to differentiate five risk models, the infrastructure needed to succeed, and pros and cons of each.</td>
<td>Approved for 3.25 AMA PRA Category 1 Credits™</td>
</tr>
<tr>
<td><strong>Teamwork, communication and patient safety: Elements of medical staff leadership in patient care</strong></td>
<td>9:30–10:30 a.m.</td>
<td>Crystal Ballroom B</td>
<td>Learn to foster a culture of accountability and openness within your medical staff and make a lasting impact on the effectiveness of your team and the quality of care.</td>
<td>Approved for 1.0 AMA PRA Category 1 Credit™</td>
</tr>
<tr>
<td><strong>Exploring the cutting edge of gene therapy in medicine</strong></td>
<td>10–11 a.m.</td>
<td>Acapulco</td>
<td>Explore the topic of gene therapy and discuss the important scientific and ethical considerations when using this technology for therapeutic purpose.</td>
<td></td>
</tr>
<tr>
<td><strong>Blockchain in health care: Hype or here to stay?</strong></td>
<td>10:45–11:45 a.m.</td>
<td>Crystal Ballroom B</td>
<td>Join the AMA-OMSS to learn more about this emerging technology and how it will transform the way that you care for your patients.</td>
<td>Approved for 1.0 AMA PRA Category 1 Credit™</td>
</tr>
<tr>
<td><strong>A day in the life of me: Tackling prejudice against providers</strong></td>
<td>11 a.m.–noon</td>
<td>Acapulco</td>
<td>Explore the prevalence of patient and institutional bias against providers in medicine, identify what groups are most likely to face discrimination and highlight the need for awareness.</td>
<td></td>
</tr>
<tr>
<td><strong>How to negotiate your employment contract</strong></td>
<td>1:20–2 p.m.</td>
<td>Columbus I/J</td>
<td>Learn how to negotiate—or renegotiate—your employment contract and mentor medical students and resident/fellow physicians as they begin to explore their career options and enter into practice.</td>
<td></td>
</tr>
</tbody>
</table>

(Continued on back)
<table>
<thead>
<tr>
<th>Time</th>
<th>Location</th>
<th>Topic</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:30–2:30 p.m.</td>
<td>Acapulco</td>
<td>After the smoke clears: Provider well-being after mass casualty incidents</td>
<td>Join the discussion about provider care and well-being when traumatic events occur.</td>
</tr>
<tr>
<td>1:30–3 p.m.</td>
<td>Crystal A</td>
<td>Understanding CMS’s new BPCI Advanced model</td>
<td>Learn key components of the Centers for Medicare &amp; Medicaid Innovation’s (CMMI) new BPCI Advanced model from Steven Farmer, MD, CMMI.</td>
</tr>
<tr>
<td>8:30–9:30 a.m.</td>
<td>Crystal Ballroom B</td>
<td>Improving health outcomes for vulnerable patient populations</td>
<td>Discover how various health determinants inform structural interventions to improve health behaviors and outcomes among elderly, LGBTQ and incarcerated patient populations.</td>
</tr>
<tr>
<td>9:45–10:45 a.m.</td>
<td>Crystal Ballroom B</td>
<td>#MeToo: Sexual harassment and discrimination in medicine</td>
<td>Learn how these issues affect patient care and how to reduce unconscious bias and inappropriate behavior in the workplace.</td>
</tr>
<tr>
<td>10:45 a.m.–noon</td>
<td>Columbus C/D</td>
<td>From disruption to reform: Learn to spark change and move medicine forward</td>
<td>With just a few key strategies, you have the power to influence the future of medicine. Learn about today’s most pressing issues and how to take smart action.</td>
</tr>
<tr>
<td>11 a.m.–noon</td>
<td>Crystal Ballroom C</td>
<td>Health care change agents: Traditional and non-traditional players fuel the fire</td>
<td>Learn to identify trends of the non-traditional and emerging players entering the health care space and evaluate the potential pros and cons.</td>
</tr>
<tr>
<td>11 a.m.–noon</td>
<td>Regency ABC</td>
<td>Small changes, big results: Innovations in patient-centered technology</td>
<td>This session will examine key technological advances in patient care and highlight what physicians need to consider when implementing new technologies in their practice.</td>
</tr>
<tr>
<td>Noon–1:30 p.m.</td>
<td>Columbus K/L</td>
<td>How to successfully transition out of medicine and into retirement</td>
<td>This session will focus on a planning process that supports a gradual transition away from medical practice while recognizing the value of experienced late-career physicians.</td>
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</tbody>
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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 each live activity for the maximum number of AMA PRA Category 1 Credits™ reflected with each session. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
# A-18 Seating Chart

A-18 Seating Chart is color coded by region.

| PA 12 | 1 | NY 12 |
| PA 12 | 2 | NY 12 |
| VA 12 | 3 | ME 2 |
| VA 12 | 4 | NH 2 |
| NJ 10 | 5 | VT 2 |
| DC 2  | 6 | RI 2 |
| WV 6  | 7 | CT 6 |
| DC 2  | 8 | MA 12 |
| MD 6  | 9 | AL 4 |
| WV 6  | 10 | NC 8 |
| KY 6  | 11 | TN 10 |
| MI 12 | 12 | AL 2 |
| MI 12 | 13 | FL 12 |
| MI 8  | 14 | OH 4 |
| OH 12 | 15 | FL 12 |
| IN 12 | 16 | GA 6 |
| IN 8  | 17 | PA 12 |
| NE 12 | 18 | NY 12 |
| MO 12 | 19 | PA 12 |
| WI 6  | 20 | NY 12 |
| IA 4  | 21 | NY 12 |
| MO 12 | 22 | NY 12 |
| IL 12 | 23 | NY 12 |
| IL 12 | 24 | NY 12 |
| CA 4  | 25 | NY 12 |
| SD 8  | 26 | NY 12 |
| CO 4  | 27 | NY 12 |
| MN 6  | 28 | NY 12 |
| TX 12 | 29 | NY 12 |
| TX 12 | 30 | NY 12 |

PIMA/NMSS/NMSO
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aerospace Medicine</td>
<td>Aerospace Medical Association</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>American Society of Anesthesiologists</td>
</tr>
<tr>
<td>Cardiology</td>
<td>American College Cardiology</td>
</tr>
<tr>
<td>Clinical Oncology</td>
<td>American Society of Clinical Oncology</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Dermatology Section Council</td>
</tr>
<tr>
<td>Echocardiography</td>
<td>American Society of Echocardiography</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>American College of Emergency Physicians</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>American Association of Clinical Endocrinologists and Endocrine Society</td>
</tr>
<tr>
<td>Hematology</td>
<td>American Society of Hematology</td>
</tr>
<tr>
<td>Hospice and Palliative Medicine</td>
<td>American Academy of Hospice and Palliative Medicine</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>Infectious Diseases Society of America</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>AMDA-The Society for Post-Acute &amp; Long-Term Care Medicine</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>American College of Physicians</td>
</tr>
<tr>
<td>Medical Genetics</td>
<td>American College of Medical Genetics and Genomics</td>
</tr>
<tr>
<td>Nephrology</td>
<td>Renal Physicians Association</td>
</tr>
<tr>
<td>Neurology</td>
<td>American Academy of Neurology</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>Society of Nuclear Medicine and Molecular Imaging</td>
</tr>
<tr>
<td>Obstetrics and Gynecology</td>
<td>American College of Obstetricians and Gynecologists (ACOG)</td>
</tr>
<tr>
<td>Occupational &amp; Environmental Medicine</td>
<td>American College of Occupational &amp; Environmental Medicine</td>
</tr>
<tr>
<td>Pain Medicine</td>
<td>American Academy of Pain Medicine</td>
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<tr>
<td>Pathology</td>
<td>American Society for Clinical Pathology (ASCP)</td>
</tr>
<tr>
<td>Pathology</td>
<td>College of American Pathologists</td>
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<tr>
<td>Preventive Medicine</td>
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<tr>
<td>Primary Care</td>
<td>American Academy of Family Physicians (AAFP)</td>
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<tr>
<td>Primary Care</td>
<td>American Academy of Pediatrics</td>
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<tr>
<td>Primary Care</td>
<td>Obesity Medicine Association</td>
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<tr>
<td>Psychiatry</td>
<td>American Academy of Child and Adolescent Psychiatry (AACAP)</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>American Association for Geriatric Psychiatry</td>
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<tr>
<td>Psychiatry</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>Public Health</td>
<td>American Association of Public Health Physicians</td>
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<tr>
<td>Pulmonary Disease</td>
<td>American College of Chest Physicians (CHEST)</td>
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<tr>
<td>Radiology</td>
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<tr>
<td>Radiology</td>
<td>Radiological Society of North America (RSNA)</td>
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<tr>
<td>Radiology</td>
<td>Society of Interventional Radiology</td>
</tr>
<tr>
<td>Sleep Medicine</td>
<td>American Academy of Sleep Medicine</td>
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<tr>
<td>Surgery</td>
<td>American Academy of Orthopaedic Surgeons</td>
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<tr>
<td>Surgery</td>
<td>American Academy of Otolaryngology-Head and Neck Surgery</td>
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<tr>
<td>Specialty</td>
<td>Medical Association</td>
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<tr>
<td>Surgery</td>
<td>American Association of Hip and Knee Surgeons</td>
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<td>Surgery</td>
<td>American College of Surgeons</td>
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<tr>
<td>Surgery</td>
<td>American Society of Plastic Surgeons</td>
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<tr>
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<td>American Society of Transplant Surgeons</td>
</tr>
<tr>
<td>Surgery</td>
<td>Society of Thoracic Surgeons</td>
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<td>Urology</td>
<td>American Urological Association</td>
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## BASIC RULES GOVERNING MOTIONS

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<tr>
<td><strong>PRIVILEGED MOTIONS</strong></td>
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<tr>
<td>1. Adjoin</td>
<td>No</td>
<td>Yes</td>
<td>Yes⁵</td>
<td>Yes⁴</td>
<td>Majority</td>
<td>None</td>
<td>Amend, close debate, limit debate</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Recess</td>
<td>No</td>
<td>Yes</td>
<td>Yes⁴</td>
<td>Yes⁴</td>
<td>Majority</td>
<td>None</td>
<td>Amend, close debate, limit debate</td>
<td>Yes⁴</td>
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<tr>
<td>3. Question of privilege</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>None</td>
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<td><strong>SUBSIDIARY MOTIONS</strong></td>
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<td>4. Table</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Main motion</td>
<td>None</td>
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<td>5. Close debate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Debatable motions</td>
<td>None</td>
<td>Yes</td>
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<td>6. Limit or extend debate</td>
<td>No</td>
<td>Yes</td>
<td>Yes⁴</td>
<td>Yes⁴</td>
<td>Majority</td>
<td>Debatable motions</td>
<td>Amend, close debate</td>
<td>Yes⁴</td>
</tr>
<tr>
<td>7. Postpone to a certain time</td>
<td>No</td>
<td>Yes</td>
<td>Yes⁴</td>
<td>Yes⁴</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend, close debate, limit debate</td>
<td>Yes⁴</td>
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<tr>
<td>8. Refer to committee</td>
<td>No</td>
<td>Yes</td>
<td>Yes⁴</td>
<td>Yes⁴</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend, close debate, limit debate</td>
<td>Yes⁴</td>
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<tr>
<td>9. Amend</td>
<td>No</td>
<td>Yes</td>
<td>Yes⁴</td>
<td>Yes⁴</td>
<td>Majority</td>
<td>Repealable motions</td>
<td>Amend, close debate, limit debate</td>
<td>No</td>
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<tr>
<td><strong>MAIN MOTIONS</strong></td>
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<td>10. (a) The main motion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Subsidiary</td>
<td>No</td>
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<tr>
<td>(b) Specific main motions</td>
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<td>Adopt in-lieu-of</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Subsidiary</td>
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<tr>
<td>Amend a previous action</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Same Vote</td>
<td>Adopted main motion</td>
<td>Subsidiary</td>
<td>No</td>
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<tr>
<td>Ratify</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Same Vote</td>
<td>Adopted main motion</td>
<td>Subsidiary</td>
<td>No</td>
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<tr>
<td>Recall from committee</td>
<td>No</td>
<td>Yes</td>
<td>Yes⁴</td>
<td>Yes⁴</td>
<td>Majority</td>
<td>Referred main motion</td>
<td>Close debate, limit debate</td>
<td>No</td>
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<tr>
<td>Reconsider</td>
<td>Yes⁴</td>
<td>Yes</td>
<td>Yes⁴</td>
<td>No</td>
<td>Majority</td>
<td>Vote on main motion</td>
<td>Close debate, limit debate</td>
<td>No</td>
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<tr>
<td>Rescind</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Same Vote</td>
<td>Adopted main motion</td>
<td>Subsidiary, except amend</td>
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## INCIDENTAL MOTIONS

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<tr>
<td><strong>MOTIONS</strong></td>
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<tr>
<td>Appeal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority⁷</td>
<td>Ruling of chair</td>
<td>Close debate, limit debate</td>
<td>No</td>
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<tr>
<td>Suspend the rules</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Procedural rules</td>
<td>None</td>
<td>Yes</td>
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<tr>
<td>Consider informally</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Main motion or subject</td>
<td>None</td>
<td>Yes</td>
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<td><strong>REQUESTS</strong></td>
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<td>Point of order</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Procedural error</td>
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<td>Inquiries</td>
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<td>No</td>
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<td>Withdraw a motion</td>
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<td>No</td>
<td>None</td>
<td>All motions</td>
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<td>Division of question</td>
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<td>No</td>
<td>None</td>
<td>Main motion</td>
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<td>Division of assembly</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Indecisive vote</td>
<td>None</td>
<td>No</td>
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</table>

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 un-debatable 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
Resolution: 1
(A-18)

Introduced by: Region 6; Regions 1; Region 5; Asian Pacific American Medical Student Association (APAMSA); Latino Medical Students Association (LMSA); Rowena Hann, Warren Stopak, and Jessica Mitter, Touro University California College of Osteopathic Medicine; Paige Anderson, University of Toledo College of Medicine and Life Sciences; Sumana Kondle, Meharry Medical College

Subject: Opposition to Regulations That Penalize Immigrants For Accessing Health Care Services

Referred to: MSS Reference Committee (Celeste Peay, Chair)

Whereas, A public charge is defined as an individual who is “primarily dependent on the government for subsistence, as demonstrated by either (i) the receipt of public cash assistance for income maintenance, or (ii) institutionalization for long-term care at government expense”., and

Whereas, The Immigration and Nationality Act dictates that if an immigration and/or consular authority concludes that an individual is likely to become a public charge, that they should be ineligible for permanent legal status, and

Whereas, The Department of Homeland Security has proposed a rule change for publication in July 2018 to consider the use of non-cash benefits, such as Children’s Health Insurance Program (CHIP), when determining whether an individual will likely become a public charge, and

Whereas, The proposed rule change would also allow for consideration of non-cash public benefits used by dependent family members, including U.S. citizen children, in determining an individual’s eligibility to obtain permanent residence status, and

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1 Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 FR § 28689 (1999).
Whereas, Columbia University’s Center on Poverty and Social Policy estimates that 560,000 citizen children will enter into poverty and 240,000 citizen children will enter into deep poverty if non-citizen parents give up non-cash food assistance benefits as a result of these proposed changes;⁵ and

Whereas, Anti-immigrant policies contribute to decreased utilization of health care and social services such as Medicaid, prenatal care, and food stamps, and thus exacerbate health disparities and illnesses in immigrant populations;⁶,⁷,⁸,⁹ and

Whereas, Anti-immigrant policies contribute to feelings of anxiety, fear, and depression, resulting in poor physical and mental health outcomes among immigrants and non-immigrant minorities;⁷,¹⁰,¹¹ and

Whereas, Health care workers across the country have reported recent trends in which immigrants with and without U.S. citizen children that are pursuing permanent residency are not utilizing health care and other social services, for fear that utilizing these services will jeopardize their chances of obtaining documentation to stay in the U.S.;¹²,¹³,¹⁴ and

Whereas, U.S. Census Bureau data from 2011-2013 indicate 45.3% of immigrant-headed households with children use food assistance programs, such as the Special Supplemental Nutrition Program for Women, Infants and Children (WIC);¹⁵ and

Whereas, States that increased the number of insured individuals by expanding Medicaid have benefitted hospital and other healthcare organizations by decreasing uncompensated care;¹⁶ and

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Whereas, Existing AMA policy “opposes federal and state legislation denying or restricting legal immigrants Medicaid and immunizations” (H-290.983), “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” (H-350.957), “advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants” (H-350.957), and “oppose[s] any legislative proposals that would criminalize the provision of health care to undocumented residents” (H-440.876); and

Whereas, Existing AMA-MSS policy opposes “Federal and state legislation denying or restricting legal immigrants Medicaid and immunizations (270.010MSS)”; therefore be it

RESOLVED, That our AMA amend H-290.983 by addition,

“Our AMA opposes federal and state legislation, policies, or regulations denying, deterring, or restricting legal immigrants and/or their dependents’ access to non-cash public health care benefits including, but not limited to, Medicaid, CHIP, WIC, SNAP, and immunizations;” and be it further

RESOLVED, That our AMA make an immediate statement to oppose regulations that would deter immigrants and/or their dependents from utilizing necessary health care services, and be it further

RESOLVED, That our AMA encourage medical providers to participate in public comment periods regarding such regulations, and be it further

RESOLVED, That this resolution be forwarded immediately to the House of Delegates at A-18.

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RELEVANT AMA AND AMA-MSS POLICY

Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth D-60.968
Our AMA will work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services.

Support of Health Care to Legal Immigrants H-290.983
Our AMA opposes federal and state legislation denying or restricting legal immigrants Medicaid and immunizations.

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.

Racial and Ethnic Disparities in Health Care H-350.974
1. 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.

2. The AMA emphasizes three approaches that it believes should be given high priority: A. 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.
B. 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.

C. 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

3. 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.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

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.

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

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.

270.010MSS
Resolution 2
(A-18)

Introduced by: Region 5; Sam Schuiteman, Sanjana Prasad, Taania Girgla, University of Michigan Medical School

Subject: Permanent Reauthorization of the Children’s Health Insurance Program

Referred to: MSS Reference Committee (Celeste Peay, Chair)

1 Whereas, The AMA supports health insurance coverage for all children as a national priority; and

2 Whereas, Enacted in 1998, the Children’s Health Insurance Program (CHIP) provides comprehensive health care insurance to over 8.9 million children and 360,000 pregnant women across the country;¹ and

3 Whereas, The purpose of CHIP is to provide health insurance to children from socioeconomically disadvantaged backgrounds, given that qualifying children live in families that earn too much to qualify for Medicaid but not enough to afford private health insurance;² and

4 Whereas, The proportion of uninsured children has dropped from 15% to 9% of all children since CHIP’s establishment in 1997, and the percentage of uninsured low-income children has fallen from 25% to 13%;³ and

5 Whereas, Children in CHIP have better access to care, fewer unmet needs, better educational performance, and greater financial protection compared to when they were uninsured;⁴ and

6 Whereas, CHIP is jointly funded by both state and federal governments, and since passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) at least 88% of the cost in each state has been covered by the federal government;⁵ and

7 Whereas, Federal funding for CHIP expired on September 30, 2017 and stable funding was not restored until January 23, 2018, and during this lapse in funding 14 states planned on freezing, freezing,

¹ Kaiser Family Foundation. (2018) “Number of Children Ever Enrolled in CHIP Annually.” Available at https://www.kff.org/other/state-indicator/annual-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
phasing out, or terminating coverage for children once their funds ran out, which would have left
611,052 children without insurance on February 1, 2018;⁶,⁷

Whereas, During previous state freezes in CHIP enrollment, affected children went almost
entirely without access to health care services and the majority of families affected reported
sustaining “significant financial hardship”;⁸,⁹ and

Whereas, while CHIP is currently funded through 2028, a permanent extension of CHIP would
prevent these vulnerable populations from going without access to health care; and

Whereas, Federal funding for CHIP expired because of political arguments about the federal
budget unrelated to health care, and elected officials used the reinstatement of funding as a
political bargaining chip¹⁰,

Whereas, A permanent extension would prevent CHIP from being inappropriately used in future
political arguments; and

Whereas, Long-term funding of CHIP actually saves money for state and federal governments,
evidenced by the Congressional Budget Office’s official estimates stating that a 5 year CHIP
extension would cost $800 million but a 10 year extension would save $6 billion, and this is
because the alternatives to CHIP (such as Medicaid and subsidized ACA marketplace
coverage) are more expensive than CHIP ;¹¹ and

Whereas, Despite CHIP’s current authorization lasting for 10 years, multiple United States
Senators have advocated for a permanent reauthorization of CHIP, which would save money for
state and federal governments, as well as provide certainty to those governments and the
families who need it; therefore be it

RESOLVED, That the AMA support permanent authorization of the Children’s Health Insurance
Program (CHIP) and oppose any future lapse in federal funding.

Fiscal Note: Minimal, 6

Date Received: 04/11/2018

RELEVANT AMA AND AMA-MSS POLICY

Medicaid Waivers and Maintenance of Effort Requirements H-290.969

Our AMA opposes any efforts to repeal the Medicaid maintenance of effort requirements in the ACA and American Recovery and Reinvestment Act (ARRA), which mandate that states maintain eligibility levels for all existing adult Medicaid beneficiaries until 2014 and for all children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019.

Health Insurance for Children H-185.948
Our AMA supports requiring all children to have adequate health insurance as a strategic priority.

Protecting Children, Adolescents and Young Adults in Medicaid and the State Children’s Health Insurance (SCHIP) Program D-290.985
Our AMA will actively: (1) encourage state and county medical societies to advocate for initiatives to ensure that all eligible children, adolescents, and young adults are enrolled in Medicaid and SCHIP; (2) advocate for federal and state funding for Medicaid and SCHIP so that funding is sufficient to support enrollment of and provision of necessary services to all eligible children, adolescents, and young adults; and (3) encourage state and county medical societies to work to ensure that services to children, adolescents, and young adults meet Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Standards.

State Children’s Health Insurance Program Reauthorization (SCHIP) D-290.982
1. Our AMA strongly supports the State Children’s Health Insurance Program reauthorization and will lobby toward this end.

2. Our AMA will lobby Congress to:
   a. provide performance-based financial assistance for new coverage costs with expanded coverage of uninsured children through (SCHIP) through an enhanced federal match;
   b. allow states to use (SCHIP) funds to augment employer-based coverage;
   c. allow states to explicitly use (SCHIP) funding to cover eligible pregnant women;
   d. allow states the flexibility to cover all eligible children residing in the United States and pregnant women through the (SCHIP) program without a mandatory waiting period;
   e. provide $60 billion in additional funding for (SCHIP) to ensure adequate funding of the (SCHIP) program and incentivize states to expand coverage to qualified children, and support incentives for physicians to participate; and
   f. ensure predictable funding of (SCHIP) in the future.

3. Our AMA will urge Congress to provide targeted funding for (SCHIP) enrollment outreach.

Increasing Coverage for Children H-165.877
Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women; (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) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children and recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (6) seeks to have introduced or support federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families; (7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package; (8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits; (9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (10) advocates consideration by
Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; and (13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program.

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.
Whereas, 55.7% of intimate partner homicides (746 deaths) were committed using a firearm in 2015; and

Whereas, Women who are threatened or assaulted with a firearm or other weapon are 20 times more likely than other women to be murdered, and when a firearm is present in the house, an abused woman is 6 times more likely than other abused women to be killed; and

Whereas, 64% of female homicide victims are killed by an intimate partner or family member (which most states define as an individual currently or previously cohabiting with the victim): 24% are killed by a spouse or ex-spouse, 21% are killed by a boyfriend or girlfriend, and 19% by another family member; and

Whereas, 28.5% of intimate partner violence-related incidents involve the death of multiple victims and approximately 70% of these corollary victims (family members, friends, neighbors, persons who intervene, law enforcement, or bystanders) are killed with a firearm; and

Whereas, The Federal Gun Control Act of 1968 makes it unlawful for certain categories of individuals, such as convicted felons, illegal drug users, and persons who are mentally ill, to

possess, receive, transport, or ship firearms or ammunition, and in 1996 the law was amended to include those convicted of a misdemeanor crime of domestic violence.\(^6\) and

Whereas, The Bureau of Alcohol, Tobacco, and Firearms defines a misdemeanor crime of domestic violence as an offense that is “committed by a current or former spouse, parent, or guardian of the victim, by a person with whom the victim shares a child in common, by a person who is cohabitating with or has cohabitated with the victim as a spouse, parent, or guardian, or by a person similarly situated to a spouse, parent, or guardian of the victim”;\(^7\) and

Whereas, 17 states expand the federal definition of domestic violence to recognize non-spouse dating partners and 43 states recognize family members, yet in the remaining states that do not have expanded purchase restrictions, these individuals may still legally purchase firearms despite a history of violence and abuse.\(^8\)

Whereas, In states that have expanded the definition of a domestic violence misdemeanor to include individuals subject to domestic violence restraining orders, the reduced ability to purchase firearms is associated with a 14-25% reduction in firearm-associated cases of intimate partner homicide;\(^8,9\) and

Whereas, A case-control study of attempted and completed intimate partner homicides found that stalking behaviors occur in the 12 months prior in 68% of cases, which suggests victims of stalking are at increased risk of being murdered by their abusers;\(^10\) and

Whereas, An analysis found 54.5% of stalking victims report their stalkers threatened to kill them and 39.6% of victims report being threatened with a weapon;\(^10\) and

Whereas, The American College of Obstetricians and Gynecologists recognizes stalking as a method of intimate partner violence;\(^11\) and

Whereas, The American Medical Women’s Association supports the expansion of legislation aimed at preventing domestic violence offenders from possessing firearms, therefore be it

RESOLVED, That our AMA support legislation that would expand the current federal prohibitions on firearm purchases to include individuals subject to domestic violence restraining orders, convicted stalkers, and persons charged with domestic violence and intimate partner violence even if no legal relationship exists.

Fiscal Note: Minimal, 5

Date Received: 04/11/18

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RELEVANT AMA AND AMA-MSS POLICY

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

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

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

Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

Gun Violence as a Public Health Crisis D-145.995

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

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

Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.
Gun Regulation H-145.999
Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

AMA Campaign to Reduce Firearm Deaths H-145.988
The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.

Waiting Period Before Gun Purchase H-145.992
The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Firearm Availability H-145.996
Our AMA: (1) Advocates a waiting period and background check for all firearm purchasers; (2) encourages legislation that enforces a waiting period and background check for all firearm 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.

Waiting Periods for Firearm Purchases H-145.991
The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Data on Firearm Deaths and Injuries H-145.984
The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.

Firearm Related Injury and Death: Adopt a Call to Action H-145.973
Our AMA endorses the specific recommendations made by an interdisciplinary, interprofessional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American 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.
Family and Intimate Partner Violence H-515.965
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.

Handgun Violence 145.001MSS
The AMA-MSS recognizes that handgun violence and accidents represent a significant public health hazard, and supports the following methods of addressing this hazard: (1) strict federal regulation of the manufacture, sale, importation, distribution, and licensing of handguns and their component parts, including a mandatory 7-day waiting period and police background check for all handgun purchases; (2) supports the taxation of handgun and handgun ammunition sales to be used to help cover medical bills for the victims of handgun violence and to fund public education on the prevention of violence; and (3) educational programs that can demonstrate a reduction in the deaths and injuries caused by handguns.

Prevention of Unintentional Firearm Accidents in Children 145.004MSS
AMA-MSS will ask the AMA to increase efforts to reduce pediatric firearm morbidity and mortality by encouraging its members: (1) to inquire as to the presence of household firearms as a part of childproofing the home; (2) to educate patients to the dangers of firearms to children; (3) to encourage patients to educate their children and neighbors as to the dangers of firearms; and (4) to routinely remind patients to obtain firearm safety locks and store firearms under lock and key; and that the AMA encourage state medical societies to work with other organizations to increase public education about firearm safety.

Gun Safety Counseling in Undergraduate Medical Education 145.011MSS
AMA-MSS will ask the AMA to (1) advocate for the inclusion of strategies for counseling patients on safe gun storage and use in undergraduate medical education; (2) add additional language to AMA Policy H-145.976 prohibiting limitations on the ability of medical students to discuss firearms with patients; and (3) advocate that the Association of American Medical Colleges, Agency for Health, Research and Quality, and other relevant professional medical societies develop gun safety counseling modules to be used in undergraduate medical education.

Use of Individualized Violence Risk Assessments in Reporting of Mental Health Professionals for Firearm Background Checks 145.012MSS
AMA-MSS encourages mental health professionals to use individualized violence risk assessments, rather than categorical exclusion criteria, in reports to state or federal authorities for firearm background checks.

Strengthening our Gun Policies on Background Checks and the Mentally Ill 145.013MSS
AMA-MSS (1) supports strengthening of the National Instant Criminal Background Check System (NICS) and encourages states to mandate reporting patients with mental illnesses who pose a risk to themselves or others so that their gun licenses can be suspended and their firearms removed until they are deemed fit; (2) encourages the use of smart gun technology on
all firearms so that only the lawful owner can discharge a weapon; and (3) supports universal background checks for people buying guns through any medium.

Preventing Fire-Arm Related Injury and Morbidity in Youth 145.014MSS
AMA-MSS will ask the AMA to collaborate with firearms owners and training organizations to develop and distribute firearm safety materials that are appropriate for the clinical setting.
WHEREAS, The AMA-MSS acknowledges HPV vaccines as beneficial to all genders as anti-cancer and anti-STI practices (MSS res 15-I-17) considering Human Papillomavirus (HPV) is known to be the primary cause of genital warts, cervical, vulvar, vaginal, anal, and oropharyngeal cancers, as well as 48% of penile cancers;¹³ and

WHEREAS, HPV vaccines are a safe and effective method of protection from viral strains 6, 11, 16, 18, 31, 33, 45, 52 and 58, which are linked to 73% of known HPV-related cancers, including 90% of cervical cancers;⁴,⁵ and

WHEREAS, The Centers for Disease Control and Prevention (CDC), the Advisory Committee on Immunization Practices (ACIP), and the AMA (D-400.055) recommend HPV vaccination administration begin for boys and girls at 11 to 12 years-old;⁶,⁷ and

WHEREAS, When HPV education and vaccination education are offered, they are often implemented in high school health curricula, while the target age group of 11 to 12-year-old children receives disproportionately less information;⁸ and

WHEREAS, Inclusion of HPV vaccination information during the ACIP recommended time frame is important for youth to be mindful of protection from HPV-related issues at the proper age;⁸ and

WHEREAS, The HPV vaccine is more effective if administered before becoming sexually active to allow viral immunity prior to HPV exposure;⁶ and

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Whereas, Parents have a tendency to underestimate the sexual activity of their child by a significant margin while data shows 41.2% of all high school students and 24.1% of ninth grade students have engaged in sexual activity;\(^9\),\(^10\) and

Whereas, Females who received vaccination in eighth grade showed significant decreases in cervical dysplasia and genital warts;\(^11\) and

Whereas, Iowa law requires public school health education provide information on HPV and HPV vaccination for middle schoolers;\(^12\) and

Whereas, Common reasons parents do not seek HPV vaccines for their children are lack of information, lack of education, and low perceived risk of HPV infection, and after HPV education intervention, 97% of parents were in support of an in-school vaccination clinic (14),\(^11\),\(^13\),\(^14\) and

Whereas, After an HPV education intervention for school staff, parents, and health professionals in Guilford County, North Carolina, over 90% of school staff felt middle school implementation of HPV education and HPV vaccine education was appropriate;\(^14\) and

Whereas, Although a concern of early HPV vaccination is its perceived effect on sexual behavior, a study following HPV vaccine exposed and unexposed girls showed receiving the HPV vaccination at the ACIP recommended age has no association with increased engagement in sexual behaviors;\(^11\),\(^15\) and

Whereas, The AMA-MSS supports increased public awareness of HPV vaccination (MSS res 15-i-17); however, it is important to specify that school health education should be targeted to parents and their children at the recommended age of vaccination and should express risks to all genders;\(^1\),\(^3\),\(^6\) and therefore be it

RESOLVED, That our AMA-MSS will ask the AMA to amend policy D170.995 with the insertion and deletion as follows:

**Comprehensive Human Papillomavirus (HPV) Inclusion in High-School Health Education Curricula D-170.995**

Our AMA will: (1) strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in both males and females, the causal relationship of HPV to genital warts and cervical cancer, vaginal cancer, and vulvar cancer in women; penile cancer in men; and oropharyngeal cancer, anal cancer, and genital warts in the general population, and the importance of routine pap smears in the early detection of cervical cancer; and (2) urge that students and parents be educated about HPV and the

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\(^12\) Iowa Department of Education. (2016). Iowa School Health Legal Reference Summary (p. 13).


Human Papillomavirus (HPV) Inclusion in High School Education Curricula

Our AMA will: (1) strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in both males and females, the causal relationship of HPV to genital warts and cervical cancer, and the importance of routine pap smears in the early detection of cervical cancer; and (2) urge that students and parents be educated about HPV and the availability of the HPV vaccine.

Insurance Coverage for HPV Vaccine

Our AMA: (1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices; (2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and (3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.

An Updated Review of Sex Education Programs in the United States

Our AMA: (1) recognizes that increasing sexually transmitted disease (STD) and human immunodeficiency virus (HIV) transmission rates among youth, as well as a recent increase in the national teen pregnancy rate, indicate a gap in public health education and should be addressed; and that comprehensive-based sex education is currently the most effective strategy to address these public health problems; and (2) supports the redirection of federal resources toward the development and dissemination of more comprehensive health and sex education programs that are shown to be efficacious by rigorous scientific methodology. This includes programs that include scientifically accurate education on abstinence in addition to contraception, condom use, and transmission of STDs and HIV, and teen pregnancy. (CSAPH Rep. 7, A-09)

Emphasizing the Human Papillomavirus Vaccines as Anticancer Prophylaxis For A Gender-neutral Demographic

AMA-MSS will ask AMA to: (1) acknowledge HPV Vaccines as beneficial to all genders as anticancer and anti-STI; and (2) support appropriate stakeholders to increase public awareness of HPV vaccines effectiveness against both HPV-related cancers and STIs.
Resolution: 5
(A-18)

Introduced by: Region 4; Austin Coye, Kasha Bornstein, Arjun Watane, University of Miami Miller School of Medicine

Subject: Federal Legalization of Syringe Exchange Programs

Referred to: MSS Reference Committee
(_____, Chair)

Whereas, the opioid epidemic continues to ravage the United States, with opioid overdoses having increased 30 percent from July 2016 through September 2017 in 52 areas in 45 states;¹

and

Whereas, more than 115 Americans die every day due to accidental overdose and this number continues to increase;² and

Whereas, HIV and Hepatitis C infections continue to spread in populations of individuals who use injection drugs;³,⁴ and

Whereas, the WHO reports the prevalence of Hepatitis C in individuals who inject drugs at 67% compared to 1-3% in the general population;⁵,⁶ and

Whereas, The Centers for Disease Control and Prevention have recognized that use of injection drugs remains the primary risk factor for HCV infection in the United States;⁷ and

Whereas, The Centers for Disease Control and Prevention have recognized that approximately one in ten new HIV diagnoses in the United States are attributed to injection drug use;⁸ and

Whereas, syringe exchanges programs have been shown to be a safe and effective public health measure to prevent deaths from overdose and limit the spread of infectious disease in the community; ³, ⁴, ⁹, ¹⁰, ¹¹, ¹² and

Whereas, a 2017 meta-analysis of thirteen systematic reviews found that syringe exchanges are effective in reducing HIV transmission and risky injection behavior;\textsuperscript{13,14,15,16} and

Whereas, syringe exchanges promote public health and safety by removing contaminated syringes from the streets and educating participants about the safe disposal of used syringes;\textsuperscript{14,15,16}\textsuperscript{17}

Whereas, studies have established that syringe exchanges do not increase crime or drug use;\textsuperscript{17,18}\textsuperscript{19} and

Whereas, the CDC reports that people who use syringe exchanges are five times more likely to enter treatment;\textsuperscript{7}\textsuperscript{20,21,22} and

Whereas, the WHO reports syringe exchanges to be cost-effective with conservative estimates showing a savings cost ratio of 4:1 given the substantial savings from preventing HIV infections;\textsuperscript{13,19}\textsuperscript{23} and

Whereas, syringe exchanges are still illegal in 28 states. Although many states have attempted state-wide legalization, including Florida, Missouri, Texas, and West Virginia, they have faced significant legislative opposition from non-medical bodies, leaving millions of people in need;\textsuperscript{20,21,22}\textsuperscript{24} and

Whereas, the WHO, the CDC, and current U.S. Surgeon General Dr. Jerome M. Adams are among proponents of syringe exchange legalization;\textsuperscript{12,23,24}\textsuperscript{25}

\textsuperscript{17} Hagan, et al. Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injections. Journal of Substance Abuse Treatment. 2000:19(3) 247-250
\textsuperscript{23} Knopf, A. (2016). CDC issues urgent call for syringe services programs. Alcoholism & Drug Abuse Weekly, 28(46), 4-5. doi:10.1002/adaw.30787
Whereas, the U.S. Congress lifted the ban in 2016 on the use of federal funds for syringe exchanges, further emphasizing the widespread acceptance of the need for such a policy; and
Whereas, there is still currently no federal legislation legalizing syringe exchanges; therefore be it:
RESOLVED, That the AMA amend policy H-95.958 (Syringe and Needle Exchange Programs) with the addition of “(4) will support federal legislation for the national legalization of syringe exchanges,” as follows:

Syringe and Needle Exchange Programs H-95.958 (2016)

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; (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; and (4) will support federal legislation for the national legalization of syringe exchanges.

Fiscal Note: Minimal, 6

Date Receive: 04/11/18

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RELEVANT AMA AND AMA-MSS POLICY:

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. AMA Res. 914, I-16

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

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
Whereas, In 2012, pharmaceutical companies in the United States spent $1.2 billion on promotional mailings and $90 million on print advertising both marketed towards physicians;¹ and

Whereas, Physicians' interactions with pharmaceutical companies and exposure to information from pharmaceutical companies have been associated with adverse prescribing patterns, including inappropriately increased frequency of prescribing, higher prescribing costs, and lower prescribing quality;²,³ and

Whereas, The emergence of electronic health records (EHRs) provides a growing platform on which pharmaceutical companies can interact with physicians and influence prescribing practices at the point of care;⁴,⁵ and

Whereas, pharmaceutical marketing strategies on EHRs have appeared in the form of digital banners, instant messaging, and targeted pop-up advertisements within the system's platform;⁶ and

Whereas, one example of a pop-up pharmaceutical advertisement in the EHR reads, “This is a promotional message from LEO Pharma relating to two LEO Pharma marketed products. Enstilar (capcipotriol/betamethasome dipropionate cutaneous foam) is a once daily, 4 week, topical foam spray formation for all severities of plaque psoriasis in adults...Would you like to

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prescribe Enstilar 60mg foam instead of [originally prescribed medication]?” with the default
option being “yes”; and

Whereas, one case showed that targeted pharmaceutical advertising strategies was correlated
in over 300% more e-prescriptions for a particular drug and over a third reduction in e-
prescriptions for a competitor’s product;⁷ and

Whereas, Florida Statute 456.43 Electronic Prescribing for Medicinal Drugs which included a
 provision opposing software in EHRs that may influence prescribing behavior, including the
 presence of pharmaceutical advertising;⁸ and

Whereas, Current AMA policy supports research and physician education on design principles
and features to improve safety, and an external, independent evaluation of EMR implementation
on patient safety (D-478.995, National Health Information Technology D-478.995); therefore be
it

RESOLVED, That our AMA oppose the presence of pharmaceutical advertising including, but
not limited to, digital banner placement, instant messaging, and pop-up ads within the electronic
health record (EHR) to influence or attempt to influence, through economic incentives or
otherwise, the prescribing decision of a prescribing practitioner at the point of care; and be it
further

RESOLVED, That our AMA support legislation banning pharmaceutical advertising in electronic
health record (EHR) systems.

⁸ Florida Statutes § 456.43
RELEVANT AMA AND AMA-MSS POLICY

Federal EMR and Electronic Prescribing Incentive Program H-478.991
Our AMA: (1) will communicate to the federal government that the Electronic Medical Record (EMR) incentive program should be made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems; (2) supports the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourages a funding structure that financially penalizes physicians that have not adopted such technology; and (3) will work with the Centers for Medicaid & Medicare Services and the Department of Defense to oppose programs that unfairly penalize or create disincentives, including e-prescribing limitations for physicians who provide care to military patients, and replace them with meaningful percentage requirements of e-prescriptions or exemptions of military patients in the percentages, where paper prescriptions are required.

Protecting Social Media Users by Updating FDA Guidelines D-105.995
Our AMA will lobby the Food and Drug Administration to: (1) update regulations to ensure closer regulation of paid endorsements of drugs or medical devices by individuals on social media; and (2) develop guidelines to ensure that compensated parties on social media websites provide information that includes the risks and benefits of specific drugs or medical devices and off-use prescribing in every related social media communication in a manner consistent with advertisement guidelines on traditional media forms.

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.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

**Prescription of Durable Medical Equipment H-330.955**

(1) Our AMA continues to voice its objection to CMS and other insurers regarding onerous requirements for the prescription of durable medical equipment. (2) Our AMA advocates that additional members of a physician-led health care team be permitted to complete the certification of medical necessity form for durable medical equipment, according to their education, training and licensure and at the discretion of the physician team leader, but require that the final signature authorizing the prescription for the durable medical equipment be the responsibility of the physician. (3) Our AMA calls for CMS to revise its interpretation of the law, and advocates for other insurers, to permit that the physician's prescription be the only certification of medical necessity needed to initiate an order for and to secure Medicare or other insurer payment for durable medical equipment. (4) Our AMA calls on physicians to be aware of the abuses caused by product-specific advertising by manufacturers and suppliers of durable medical equipment, the impact on the consumers of inappropriate promotion, and the contribution such promotion makes to unnecessary health care expenditures.

**Physician Practice Drift H-410.951**

Our AMA will: (1) continue to work with interested state and national medical specialty societies to advance truth in advertising legislation, and (2) continue to monitor legislative and regulatory activity related to physician practice drift.

**Inappropriate Pharmacy Advertising H-100.958**

Our AMA supports legislation or regulation that prohibits pharmacies and pharmacy benefit managers from using patient-specific drug information to directly market to patients.

**Deceptive Health Care Advertising H-175.992**

Our AMA (1) encourages and assists all physicians and medical societies to monitor and report to the appropriate state and federal agencies any health care advertising for which there is a reasonable, good-faith basis for believing that said advertising is false and/or deceptive in a
material fact, together with the basis for such belief; and (2) encourages medical societies to keep the Association advised as to their actions relating to medical advertising.

**Support of American Drug Industry H-100.995**
Our AMA continues to support the American pharmaceutical manufacturing industry in its efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy for the benefit of the American people.

**105.001MSS Drug Advertising to the Public**
AMA-MSS will ask the AMA to oppose the promotion of drugs in the absence of reasonable evidence for claims made.
Whereas, Current AMA policy calls for physicians to “report the results of research accurately, including subsequent negative findings”, particularly when “the findings do not support the research hypothesis”; and

Whereas, There are currently hurdles to the publication of negative research findings because of the systemic phenomenon known as publication bias wherein journals are less likely to accept manuscripts reporting negative findings; and

Whereas, The AMA supports the reproducibility of research findings by advocating that scientific research “employ study designs that will yield scientifically valid and significant data”; and

Whereas, There is a systemic lack of reproducibility among published biomedical research studies, as highlighted by a recent report that nearly 70% of researchers were unable to reproduce another scientist’s results; and

Whereas, Preregistration of a research study is the act of committing to clearly defined research questions and analytical plans prior to the observation of the research outcomes, usually achieved by posting the analysis plan to an independent registry; and

Whereas, Use of a priori hypotheses in cancer epidemiological studies has been associated with a four-fold reduction in rates of reporting false positive findings, suggesting that preregistration can increase replicability of research; and

1. AMA Code of Medical Ethics policy 7.2.1 Principles for Disseminating Research Results
3. AMA Code of Medical Ethics policy 7.1.3 Study Design and Sampling
Whereas, The proportion of large clinical trials reporting negative findings increased from 43% to 92% after preregistration of clinical trials became mandatory in the United States, showing that “preregistration is correlated with outcomes that suggest reduced publication or reporting biases;” and be it further,

RESOLVED, That our AMA support practices that encourage preregistration of research studies in order to mitigate publication bias and improve the reproducibility of biomedical research.

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RELEVANT AMA AND AMA-MSS POLICY

7.1.3 Study Design & Sampling
To be ethically justifiable, biomedical and health research that involves human subjects must uphold fundamental principles of respect for persons, beneficence, and justice. These principles apply not only to the conduct of research, but equally to the selection of research topics and study design.

Well-designed, ethically sound research aligns with the goals of medicine, addresses questions relevant to the population among whom the study will be carried out, balances the potential for benefit against the potential for harm, employs study designs that will yield scientifically valid and significant data, and generates useful knowledge. For example, research to develop biological or chemical weapons is antithetical to the goals of the medical profession, whereas research to develop defenses against such weapons can be ethically justifiable.

Physicians who engage in biomedical or health research with human participants thus have an ethical obligation to ensure that any study with which they are involved:

(a) Is consistent with the goals and fundamental values of the medical profession.

(b) Addresses research question(s) that will contribute meaningfully to medical knowledge and practice.

(c) Is scientifically well designed to yield valid data to answer the research question(s), including using appropriate population and sampling controls, clear and appropriate inclusion/exclusion criteria, a statistically sound plan for data collection and analysis, appropriate controls, and when applicable, criteria for discontinuing the study (stopping rules).

(d) Minimizes risks to participants, including risks associated with recruitment and data collection activities, without compromising scientific integrity.

(e) Provides mechanisms to safeguard confidentiality.

(f) Does not disproportionately recruit participants from historically disadvantaged populations or populations whose ability to provide fully voluntary consent is compromised. Participants who otherwise meet inclusion/exclusion criteria should be recruited without regard to race, ethnicity, gender, or economic status.

(g) Recruits participants who lack the capacity to give informed consent only when the study stands to benefit that class of participants and participants with capacity would not yield valid results. In this event, assent should be sought from the participant and consent should be obtained from the prospective participant’s legally authorized representative, in keeping with
ethics guidance.

(h) Has been reviewed and approved by appropriate oversight bodies.

7.2.1 Principles for Disseminating Research Results
Physicians have an ethical responsibility to learn from and contribute to the total store of scientific knowledge. When they engage in biomedical or health research, physicians have obligations as scientists, which include disseminating research findings. Prompt presentation to scientific peers and publication of research findings are foundational to good medical care and promote enhanced patient care, early evaluation of clinical innovations, and rapid dissemination of improved techniques.

To fulfill their ethical responsibilities with respect to sharing research findings for the ultimate benefit of patients, physicians should:

(a) Advocate for timely and transparent dissemination of research data and findings. Physicians should not intentionally withhold information for reasons of personal gain.

(b) Report the results of research accurately, including subsequent negative findings. This is particularly important where the findings do not support the research hypothesis.

(c) Maintain a commitment to peer review.

(d) Disclose sponsorship and conflicts of interest relating to the research, in keeping with ethics guidance.

(e) Be responsible in their release of research results to the media, ensuring that any information the researcher provides is prompt and accurate and that informed consent to the release of information has been obtained from research participants (or participants’ legally authorized representative when the participant lacks decision-making capacity) prior to releasing any identifiable information.

In rare circumstances, the potential for misuse of research results could affect the decision about when and whether to disseminate research findings. Physician-researchers should assess foreseeable ramifications of their research in an effort to balance the promise of benefit against potential harms from corrupt application. Only under rare circumstances should findings be withheld, and then only to the extent required to reasonably protect against misuse.

Food Additives H-150.998
Our AMA supports the passage of legislation that would amend the Food Additive Act to require evidence based upon scientifically reproducible studies of the association of food additives with an increased incidence of cancer in animals or humans at dosage levels related to the amounts calculated as normal daily consumption for humans before removal of an additive from the market.

Increasing Minority Participation in Clinical Research H-460.911
1. Our AMA advocates that:
a. The Food and Drug Administration (FDA) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of
enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
b. The FDA have a page on its website that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and
c. Resources be provided to community level agencies that work with those minorities who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities in clinical trials:
a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders’ support, and listening to community’s needs;
b. Increased outreach to female physicians to encourage recruitment of female patients in clinical trials;
c. Continued minority physician education on clinical trials, subject recruitment, subject safety, and possible expense reimbursements;
d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and
e. Fiscal support for minority recruitment efforts and increasing trial accessibility through transportation, child care, reimbursements, and location.

3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.
Whereas, Alcohol-Related Liver Disease (ALD) is a term that refers to a spectrum of diseases such as cirrhosis, hepatocellular carcinoma, and liver fibrosis that are caused by alcohol consumption;¹ and,

Whereas, Alcohol use disorder (AUD) is an addiction and type of substance use disorder characterized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) by clinically significant impairments in health, social function, and voluntary control over substance use;²,³,⁴,⁵ and,

Whereas, The Six-Month Abstinence Period created during the Consensus Conference on Liver Transplantation in 1996 recommends that patients with ALD not be placed on a liver transplant list until proving sobriety after six months;⁶ and,

Whereas, Insurance companies typically enforce a six-month abstinence period for patients with ALD to be eligible for coverage;⁷ and,

Whereas, ALD is the second most common reason for a person requiring a liver transplant in the United States;⁸ and,

³ Grant BF, Goldstein RB, Saha TD, Chou SP, Jung J, Zhang H,…Hasin DS. (2015). Epidemiology of DSM-5 alcohol use disorder results from the national epidemiologic survey on alcohol and related conditions III. JAMA Psychiatry, 72(8), 757-766.
⁷ Ibid.
Whereas, The six-month abstinence period does not reliably predict post-transplant abstinence and adherence; and,

Whereas, A meta-analysis found that only 5 of 13 studies identified abstinence as a predictor for alcohol relapse post-transplant; however, the precise duration of abstinence is not consistent; and,

Whereas, More consistent predictors of post-transplant alcohol use have been found to be age of the patient, social support, and psychiatric comorbidities to be predictive of relapse while pre-transplant abstinence remains controversial; and

Whereas, United Network of Organ Sharing (UNOS) recommends the six-month abstinence rule although there is still questionable data concerning its effectiveness; and,

Whereas, The American College of Gastroenterology guidelines for treatment of alcoholic liver disease states that determining transplant candidates should not be based solely on six-month abstinence, and should incorporate other criteria; and

Whereas, Post-operative short-term survival rates for patients with ALD were comparable to patients with non-alcohol related liver disease and patients with ALD were largely adherent to follow-up care and abstained from heavy drinking; and,

Whereas, A study of transplantation without the six-month abstinence period showed that 77% survived to six months compared with just 23% of matched patients not offered early transplant; and,

Whereas, The American College of Gastroenterology guidelines for treatment of alcoholic liver disease states that determining transplant candidates should not be based solely on six-month abstinence, and should incorporate other criteria; and

Whereas, The risk of death in patients with liver disease is highest in patients with ALD; and,

Whereas, the six-month survival rate is approximately 30% for patients whose hepatitis is not responding to medical therapy; and,

Whereas, The six-month abstinence rule has been commonly employed in North America and Europe; however, recent evidence is causing more countries to loosen these restrictions; and,

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Whereas, Seven transplant centers in France took part in a study to perform early liver transplantation in patients with severe alcoholic hepatitis not responding to medical therapy, which found positive outcomes and low risk of relapse for those patients receiving early transplants; and,

Whereas, Due to the lack of evidence supporting the six-month abstinence rule, Ontario has recently introduced a three-year pilot program to remove the six-month sobriety rule for some patients; and,

Whereas, In the USA, some large transplant centers including Johns Hopkins, New York Presbyterian, and University of Maryland recognize that the standard policy is out of date and have transitioned to a more compassionate approach more in keeping with the evidence; and,

Whereas, The AMA has previously found it necessary to establish a position concerning UNOS policy (H-370.960); therefore be it

RESOLVED, That our AMA oppose the current standard of a six-month alcohol abstinence period for alcohol-related liver disease patients who require liver transplants, and further be it

RESOLVED, That our AMA supports the use of evidence-based guidelines for determining liver transplant waiting periods in alcohol-related liver disease

Fiscal Note: Minimal, 5

Date Received: 04/11/18

RELEVANT AMA AND AMA-MSS POLICY

Evidence-Based Utilization of Services D-410.992
Our AMA supports physician-led, evidence based, efforts to improve appropriate utilization of medical services and will educate member physicians, hospitals, health care leaders and patients about the need for physician-led, evidence based, efforts to improve appropriate utilization of medical services.”

UNOS Kidney Paired Donation Program H-370.960
Our AMA: (1) encourages the continued expansion of the United Network for Organ Sharing’s (UNOS) Kidney Paired Donation program which provides a national registry of living donors, carries out ongoing data collection on key issues of concern in transplantation from living donors, and through its operational guidelines provides consistent, national standards for the transplant community; and (2) encourages voluntary coordination among private donor registries and UNOS to enhance the availability of organs for transplantation.

23 Kane G. (2017). In Ontario, individuals with alcoholic liver disease will not have to wait six months for liver transplants. NCADD Addiction Medicine Update.
Transplantable Organs as a National Resource H-370.990
Our AMA: (1) supports the United Network of Organ Sharing (UNOS) policy calling for regional allocation of livers to status 1 (most urgent medical need) patients as an effort to more equitably distribute a scarce resource; (2) opposes any legislation, regulations, protocols, or policies directing or allowing governmental agencies to favor residents of a particular geo-political jurisdiction as recipients of transplantable organs or tissues; (3) reaffirms its position that organs and tissues retrieved for transplantation should be treated as a national, rather than a regional, resource; and (4) supports the findings and recommendations of the Institute of Medicine Committee on Organ Procurement and Transplantation Policy.

Methadone Maintenance and Transplantation H-370.973
Our AMA: (1) urges transplant centers across the nation to abrogate any policies that automatically exclude patients maintained on methadone from liver transplant recipient waiting lists; and (2) encourages transplant centers to assess patients maintained on methadone on a case-by-case basis using medically appropriate criteria supportable by peer-reviewed and published research.

Alcohol Use Disorder as a Disability H-30.995
(1) The AMA believes that alcohol use disorder is in and of itself a disabling condition. (2) The AMA encourages the availability of appropriate services to persons suffering from multiple disabilities, including alcohol use disorder. (3) The AMA endorses the position that printed and audiovisual materials pertaining to the subject of people suffering from both alcohol use disorder and other disabilities include the terminology "person with alcohol use disorder and other disabilities." This language clarification is intended to reinforce the concept that alcohol use disorder is in and of itself a disabling condition.
WHEREAS, Our AMA currently supports increased awareness of human trafficking and increasing education about available support resources for physicians addressing trafficking victims (H-65.956); and

WHEREAS, Our AMA currently supports the development of improved laws and policies to address commercial sexual exploitation and sex trafficking of minors by promoting care instead of arrest and prosecution (H-60.912), but no such policy exists for adult victims or for victims of labor trafficking; and

WHEREAS, Roughly equivalent numbers of homeless young adults reported experiencing labor trafficking exploitation as sex trafficking (32.1% vs 31%);¹ and

WHEREAS, The average age of first labor trafficking experience of surveyed homeless young adults was 16.5 years old, with only 35% being labor trafficked before the age of 18;¹ and

WHEREAS, A 2012 San Diego State University study identified that 31% of undocumented, Spanish-speaking migrant workers were victims of labor trafficking, estimating 38,458 labor trafficking victims in San Diego County alone;² and

WHEREAS, While official statistics are scarce, the National Human Trafficking Hotline has identified well over 5,400 labor trafficking cases since 2007, where each case may represent multiple victims;³ and

WHEREAS, The National Human Trafficking Hotline has identified roughly twice as many cases of human trafficking of adults versus minors every year since 2012;⁴ and

¹ Roe-Sepowitz D, Bracy K, Hogan K, Brockie M. Youth Experiences Survey: Exploring the Sex Trafficking Experiences of Homeless Young Adults in Arizona, Year 4. The McCain Institute for international Leadership; 2017.
Whereas, Of human trafficking cases identified by the National Human Trafficking Resource Center in 2015, 81% and 63% of labor and sex trafficking cases, respectively, involved adult victims; therefore be it

RESOLVED, That AMA Policy H-60.912, “Commercial Exploitation and Human Trafficking of Minors,” be amended by deletion and by addition to read as follows:

Commercial Exploitation and Human Trafficking of Minors, H-60.912

Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors, sex and labor trafficking victims by promoting care and services for victims instead of arrest and prosecution.

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Fiscal Note: Minimal, 6

Date Received: 04/11/18

RELEVANT AMA AND AMA-MSS POLICY

Commercial Exploitation and Human Trafficking of Minors H-60.912

Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

Physicians Response to Victims of Human Trafficking H-65.966

(1) Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking. Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The Polaris Project -
In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:
- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
  a. An assessment tool for health care professionals
  b. Online training in recognizing and responding to human trafficking in a health care context
  c. Speakers and materials for in-person training
  d. Links to local resources across the country

The Rescue & Restore Campaign -
The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

(2) Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.
The Identification and Protection of Human Trafficking Victims: AMA-MSS (1) supports the development of educational initiatives to train medical students, residents and physicians to understand their role in treating and screening for human trafficking in suspected patients; (2) supports AMA encouragement of editors and publishers of medical training literature to include indications that a patient might be a victim of human trafficking and suggested screening questions as created by Department of Health and Human Services; (3) Supports the AMA working with the Department of Health and Human Services, and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of human trafficking and to provide a conduit to resources that can better address all of the victim's medical, legal and social needs; and (4) encourages physicians to act as first responders in addressing human trafficking.

Advocating for Optimal Screening and Management of Human Trafficking Victims by Formal Education of Healthcare Professionals on this Issue through Integration of this Topic into Continuing Medical Education Requirements and Undergraduate Medical Curriculum throughout the USA: The MSS formally establishes support for the following HOD policy: H-65.966 Physicians Response to Victims of Human Trafficking. (MSS Late Res 8, I-14)
Whereas, Approximately 32.5 million adults age 50 and older have mild-to-moderate hearing loss; and

Whereas, Hearing loss prevalence will nearly double by 2060; and

Whereas, Individuals with hearing loss are at increased risk for developing dementia, falling, being hospitalized; and

Whereas, In patients aged 18 - 69, hearing loss is significantly associated with a greater risk of developing depression; and

Whereas, Less than 15% of adults aged 50 and older with mild-to-moderate hearing loss use hearing aids; and

Whereas, The President’s Council of Advisors on Science and Technology report that cost is the greatest barrier to hearing aid access; and

Whereas, Over 75% of individuals with hearing loss identify cost as a barrier to hearing aid access\(^{12}\); and

Whereas, Lower adoption rates of hearing aids are found in low income status and racial and ethnic minority patients\(^{13}\); and

Whereas, Hearing aid and audiological service cost bundling directly contribute to the high cost of hearing aids\(^{11,14}\); and

Whereas, The FDA Reauthorization Act of 2017 (H.R. 2430) provides patients with mild-to-moderate hearing loss the option to purchase self-fitted hearing aids without a medical evaluation\(^{15}\); and

Whereas, The FDA Reauthorization Act of 2017 (H.R. 2430) acts to unbundle payment plans and spur competition in a stagnant market, reducing costs and increasing access\(^{15}\); and

Whereas, Self-fitted hearing aids are effective in treating mild-to-moderate hearing loss\(^{16}\); and

Whereas, AMA policy H-35.967 promotes physicians as the gatekeepers to traditional bundled treatments of hearing loss; and

Whereas, AMA policy 11.1.4 states that physicians have an ethical responsibility to ensure that patients’ financial barriers do not limit access to appropriate healthcare; therefore be it

RESOLVED, That our AMA-MSS stand in favor of a change in the delivery model for the treatment of mild-to-moderate hearing loss through supporting over-the-counter hearing aids


Fiscal Note: Minimal, 6

Date Received: 04/11/18

RELEVANT AMA AND AMA-MSS POLICY

H-185.929, Hearing Aid Coverage

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.

H-35.967, Treatment of Persons with Hearing Disorders

1. Our AMA believes that physicians should remain the primary entry point for care of patients with hearing impairment and continue to supervise and treat hearing, speech, and equilibratory disorders.
2. Our AMA expressly opposes statements that the practice of audiology includes the diagnosis and treatment of hearing disorders; affirms that it is in the public interest that a medical assessment of any hearing or balance malfunction be made by a physician knowledgeable in diseases of the ear; reasserts that audiologists are individuals who

perform non-medical testing, evaluating, counseling, instruction and rehabilitation of individuals whose communication disorders center in whole or in part in hearing function; and affirms its respect for the contribution which audiologists have made and continue to make to patient welfare and quality health care in their assistance in the treatment of hearing disorders.

3. Should there be ambiguities in the statutory language of any state which defines audiology, state, and/or specialty medical societies should take steps to seek a legislative amendment to that statute to secure language that describes appropriately the practice of audiology. Misrepresentation by audiologists of their skills and/or the scope of their practice should be reported to appropriate state authorities.

11.1.4, Financial Barriers to Healthcare Access

Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means. In view of this obligation,

(a) Individual physicians should: (i) take steps to promote access to care for individual patients, such as providing pro bono care in their office or through freestanding facilities or government programs that provide health care for the poor, or, when permissible, waiving insurance copayments in individual cases of hardship. Physicians in the poorest communities should be able to turn for assistance to colleagues in more prosperous communities. (ii) help patients obtain needed care through public or charitable programs when patients cannot do so themselves. (b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care. (c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services. (d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people.
Whereas, Diabetes continues to be a growing public health concern for the US;¹ and diabetic retinopathy (DR) remains the leading cause of new cases of blindness in the US², with around 40-45% of patients diagnosed with diabetes also diagnosed with DR;³ and

Whereas, Early DR is often asymptomatic³, and over 73% of patients over 40 with DR are unaware of their condition;⁴ and

Whereas, Vision loss due to DR can be irreversible, however, early detection and timely treatment can reduce the risk of severe vision loss by 95%;³ as such, annual screening in diabetic patients is pivotal in reducing rates of avoidable vision impairment in the US; and

Whereas, Adherence to the recommended regular eye exam guidelines has been suboptimal among patients with diabetes, with more than 70% of patients with diabetes reporting nonadherence to annual screening recommendations;⁵ and

Whereas, Factors that had the greatest influence on low screening rates among DR patients included low socioeconomic status, minority group affiliation, lack of patient education, limited eye care or specialty care access, and geographic limitations;²,⁵,⁶,⁷,⁸ and

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Whereas, Numerous studies have emerged supporting the accuracy and effectiveness of telemedicine in screening for DR via the use of nonmydriatic fundus photography with remote image interpretation by a licensed ophthalmologist;\textsuperscript{6,7,8,9} and

Whereas, Retinal telescreening significantly reduced wait time and improved the rate of DR evaluation for diverse patients in underserved and rural settings when implemented during primary care appointments;\textsuperscript{6,7,8,9,10} and

Whereas, Existing AMA policy encourages the continued exploration of telemedicine to improve access to eye care for Veterans (H-510.982), however, no policy exists on the use of these screening methods to improve access to eye care for all underserved populations; and

Whereas, Existing AMA policy formally endorses efforts to increase education (D-440.935, H-440.844, H-160.938) and prevention (H-440.844, H-440.838) of diabetes for improved public health outcomes, however, the AMA does not formally endorse any prevention efforts for potentially devastating diabetic sequelae such as diabetic retinopathy; therefore be it

RESOLVED, That our AMA encourage the use of diabetic retinopathy telescreening in primary care centers for patients with diabetes in underserved or remote locations.

Fiscal Note: Moderate, 9

Date Received: 04/11/2018

**RELEVANT AMA AND AMA-MSS POLICY**

**VA Technology-Based Eye Care Services H-510.982**

Our AMA encourages the Department of Veterans Affairs to continue to explore telemedicine approaches that increase access to quality health care to U.S. veterans, including the Technology-Based Eye Care Services (TECS) program; and will work with Congress to ensure that U.S. veterans can access eye care through the TECS program.

**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.


Eye Exams for the Elderly H-25.990

Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings.

National Diabetes Education Program H-440.861

Our AMA formally endorses the work of the National Diabetes Education Program (NDEP), a joint venture of the National Institutes of Health, the Centers for Disease Control and Prevention, and over 200 organizations, and will seek inclusion in the NDEP Steering Committee to help guide the development of diabetes educational materials in line with existing AMA policy.

Ensuring the Best In-School Care for Children with Diabetes H-60.932

Our AMA policy is that physicians, physicians-in-training, and medical students should serve as advocates for pediatric patients with diabetes to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections.

Genomic-Based Approaches to the Risk Assessment, Management and Prevention of Type 2 Diabetes H-440.838

Our AMA encourages continued research into the potential of genomic information to improve risk assessment, management and prevention of type 2 diabetes, and will report back on important advances as appropriate.

Expansion of National Diabetes Prevention Program H-440.844

Our AMA: (1) supports evidence-based, physician-prescribed diabetes prevention programs, (2) supports the expansion of the NDPP to more CDC-certified sites across the country; and (3) will support coverage of the NDPP by Medicare and all private insurers.

Strategies to Increase Diabetes Awareness D-440.935

Our AMA will organize a series of activities for the public in collaboration with health care workers and community organizations to bring awareness to the severity of diabetes and measures to decrease its incidence.

Disease-Specific Self-Management Programs H-160.938

The AMA: (1) will work with invited medical groups to promote the physician-led team approach to disease-specific patient care as providing the highest quality of patient care; (2) insists that evidence-based disease-specific (e.g., diabetes and asthma) education services and self-management training be initiated and continued under the direction of a physician; (3) believes all changes of care or medications by members of the team should be supervised by a physician; (4) will seek to have physician-directed benefits of evidence-based disease-specific
education and self-management training provided to the beneficiaries of Medicare, Medicaid, other publicly supported programs, and all other payers; and (5) believes that status reports and all changes made by the disease-specific self-management team be transmitted in a timely fashion to the primary care physician, if the primary care physician is not the supervisor of the management team.

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)

440.025MSS Increasing Access to Healthcare by Correcting Treatable Disturbances in Visual Acuity to Improve Public Health Outcomes:
AMA-MSS will ask the AMA to: (1) encourage the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) support referring those seeking a driver's license who fail a vision screening at their respective Department of Motor Vehicles to an appropriate healthcare provider for a complete dilated eye exam and information about free health coverage programs when necessary or applicable. (MSS Res 16, A-05) (AMA Amended Res 813, I05 Adopted [H-25.990]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)
AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution 12
(A-18)

Introduced by: Anum Naseem, Tabitha Moses, Firas Askar, Leo Hall, Melanie Hartenian, Suha Syed, Brianna Sohl, Veronica Vigilar, Wayne State University; Krista Allen, Rocky Vista University; Cindy Tsui, SUNY Downstate University; Daniel Pereira, Vanderbilt University; Region 5; Region 7; Region 4

Subject: Increasing Patient Access to Sexual Assault Nurse Examiners

Referred to: MSS Reference Committee
(Celeste Peay, Chair)

Whereas, 1 in 6 women and 1 in 33 men have experienced an attempted or completed rape in their lifetime, and there were 323,450 reports of rape or sexual assault in the United States in 2016, and

Whereas, Hospital Emergency Departments (EDs) typically serve as the primary point of care for survivors of sexual assault, accounting for approximately 65,000–90,000 emergency department visits per year; and

Whereas, The Medical Forensic Examination (MFE) consists of a full head-to-toe physical examination focused on documenting a patient’s physical injuries and procuring DNA evidence to assist in the prosecution of a case; and

Whereas, The inclusion of a MFE in a case has been shown to increase prosecution rates, and patients who have chosen to undergo the MFE may do so to gain closure and emotional healing from the traumatic event; and

Whereas, The MFE can be completed by a variety of healthcare providers including Emergency Medicine (EM) physicians, nurses, physician assistants, and nurse practitioners, though EM physicians remain the primary provider performing these exams despite recommendations that discourage this practice; and

Whereas, EM physicians typically see 2.48 patients per hour, making it difficult for them to effectively complete the MFE which is less emergent but still time sensitive as it must be completed within 72 hours of the assault;\(^7\), \(^4\)

Whereas, The MFE takes on average two hours to perform and chain of custody must be maintained wherein the evidence cannot be left unattended for the entirety of the exam, until it is sealed for storage or handed to an authorized agent, making it cumbersome for EM physicians to complete in the chaotic milieu of the ED;\(^8\), \(^4\)

Whereas, Under federal law, the provider completing the MFE may be called to testify as a fact witness, which many physicians are not trained to do, potentially undermining the patients case;\(^9\)

Whereas, There is currently no national consensus on EM residents’ education of sexual assault examinations suggesting that EM physicians are not effectively trained to complete the MFE;\(^10\)

Whereas, In contrast, Sexual Assault Nurse Examiners (SANE) are the only health care personnel especially trained to perform the MFE and their involvement in care is associated with improved outcomes for patients, including psychological recovery and increased prosecution rates due to better collection of forensic data;\(^11\), \(^12\)

Whereas, Although there are now over 600 SANE programs nationwide, many EDs lack such specific expertise, especially in rural or smaller communities;\(^13\), \(^14\)

Whereas, The United States Government Accountability Office recently released a study reviewing the low availability of SANE programs that highlighted the American Hospital Association’s lack of policies or protocols regarding both patient access to examiners and nurse access to SANE training;\(^15\)

Whereas, A review conducted by the Police Foundation in Texas found that there is “reluctance by nurses, hospital administrators and criminal justice officials to having non-SANEs conduct medical forensic exams”, a position held by The Department of Justice, the International Association of Forensic Nurses and the American College of Emergency Physicians, all of


whom recommend that the MFE be performed by specially trained medical personnel such as
SANE;\textsuperscript{16,14} and

Whereas, Expanding the SANE program nationwide may decrease the burden on ED
physicians and subsequently provide better care to sexual assault survivors;\textsuperscript{4,15,16} therefore be it

RESOLVED, That our AMA advocate for increased patient access to Sexual Assault Nurse
Examiners in the Emergency Department, including the transfer of victims to other facilities with
Sexual Assault Nurse Examiners when they are not available.

Fiscal Note: Significant, 12

Date Received: 03/28/18

RELEVANT AMA AND AMA-MSS POLICY

Sexual Assault Survivors (H-80.999)
1. Our AMA supports the preparation and dissemination of information and best practices
intended to maintain and improve the skills needed by all practicing physicians involved in
providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with
state medical societies to ensure that each state implements these rights, which include but are
not limited to, the right to: (A) receive a medical forensic examination free of charge, which
includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of
injuries, and collection of forensic evidence; (B) preservation of a sexual assault evidence
collection kit for at least the maximum applicable statute of limitation; (C) notification of any
intended disposal of a sexual assault evidence kit with the opportunity to be granted further
preservation; (D) be informed of these rights and the policies governing the sexual assault
evidence kit; and (E) access to emergency contraception information and treatment for
pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for
implementing best practices in the treatment of sexual assault survivors, including through
engagement with the joint working group established for this purpose under the Survivor's Bill of
Rights Act of 2016.

Sexual Assault Survivor Services (H-80.998)
Our AMA supports the function and efficacy of sexual assault survivor services, supports state
adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of
2016, encourages sexual assault crisis centers to continue working with local police to help
sexual assault survivors, and encourages physicians to support the option of having a counselor
present while the sexual assault survivor is receiving medical care.

Access to Emergency Contraception (H-75.985)

It is the policy of our AMA: (1) that physicians and other health care professionals should be
encouraged to play a more active role in providing education about emergency contraception,
including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.

HIV, Sexual Assault, and Violence (H-20.900)

Our AMA believes that HIV testing should be offered to all victims of sexual assault, that these victims should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained.

515.010MSS Sexual Assault Survivors’ Rights:

AMA-MSS will ask that our AMA (1) advocate for the legal protection of sexual assault survivors’ rights and will work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (i) receive a medical forensic examination free of charge, which includes but is not be limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (ii) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (iii) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (iv) be informed of these rights and the policies governing the sexual assault evidence kit; and (2) collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor’s Bill of Rights Act of 2016. (MSS Res 21, A-17)
Whereas, The average 2017 cost of attendance for a public medical school was between $35,932 and $57,492 depending on residency status, and the average total debt for 2017 medical graduates was $190,694;\textsuperscript{1,2} and

Whereas, The AMA found that 43% of medical students listed debt repayment as their top personal financial concern and 55% planned on beginning repayments during their first year of residency;\textsuperscript{3} and

Whereas, An estimated 26.6% of US medical students experience depression or depressive symptoms and are more likely to experience depression during medical school than at any other stage in training, despite beginning medical school with equal or better mental health than age-similar controls;\textsuperscript{4,5,6,7} and

Whereas, Approximately 2751 (3.4%) medical students dropped out from 80,920 matriculating students between 2005 and 2009;\textsuperscript{8} and

Whereas, Psychological morbidity was likely a factor in 40% of medical school dropouts in 47 different countries between 2001 and 2011;\textsuperscript{9} and

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Whereas, Serious mental illness is associated with a reduction in individual earnings equal to 25.5% of the mean national average,¹⁰ and

Whereas, Based on current formulas for a 20-year income-based repayment plan using average medical student debt and income values for bachelor degree-holders, the average withdrawn mentally ill student could eventually be required to report a forgiven loan amount of up to $378,445 once unpaid accrued interest is added to the unpaid amount. This amount would then be considered taxable income;¹¹,¹²,¹³ and

Whereas, A discharge of student loans following undue hardships through declaration of bankruptcy is extraordinarily difficult in most circuit courts, may still carry a tax burden, and a declaration of bankruptcy remains on a credit report for 7-10 years;¹⁴,¹⁵,¹⁶,¹⁷ and

Whereas, High financial debt, especially relative to available assets, is associated with higher perceived stress, depression, psychotic disorders, and suicide;¹⁶,¹⁹,²⁰ and

Whereas, Existing AMA-MSS policy encourages “research into the number of US medical students with mental health and/or substance abuse concerns who either: 1. do not seek treatment due to the cost involved, or 2. have sought treatment, but do not feel that it has been adequate due to yearly visit and dollar limits placed on their care by their insurance plan.” (295.164MSS); and

Whereas, Existing AMA policy calls for the study of medical student mental health, the expansion of financial assistance programs, and the prioritization of reducing medical student debt (H-295.858, Access to Confidential Health Services for Medical Students and Physicians) (H-305.928, Proposed Revisions to AMA Policy on Medical Student Debt) (D-305.978, Mechanisms to Reduce Medical Student Debt); therefore be it

RESOLVED, that our AMA-MSS support the study of federal mechanisms for dismissing federal loan obligations for students who withdraw from medical school due to a diagnosed mental illness


RELEVANT AMA AND AMA-MSS POLICY

Proposed Revisions to AMA Policy on Medical Student Debt H-305.928

1. Our AMA will make reducing medical student debt a high priority for legislative and other action and will collaborate with other organizations to study how costs to students of medical education can be reduced.

2. Our AMA supports stable funding for medical schools to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue and should oppose mid-year and retroactive tuition increases.

3. Financial aid opportunities, including scholarship and loan repayment programs, should be available so that individuals are not denied an opportunity to pursue medical education because of financial constraints.

4. A sufficient breadth of financial aid opportunities should be available so that student specialty choice is not constrained based on the need for financial assistance.

5. Our AMA supports the creation of new and the expansion of existing medical education financial assistance programs from the federal government, the states, and the private sector.

6. Medical schools should have programs in place to assist students to limit their debt. This includes making scholarship support available, counseling students about financial aid availability, and providing comprehensive debt management/financial planning counseling.

7. Our AMA supports legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit the full deductibility of interest on student loans.

8. Medical students should not be forced to jeopardize their education by the need to seek employment. Any decision on the part of the medical student to seek employment should take into account his/her academic situation. Medical schools should have policies and procedures in place that allow for flexible scheduling in the case that medical students encounter financial difficulties that can be remedied only by employment. Medical schools should consider creating opportunities for paid employment for medical students.

9. Financial obligations, such as repayment of loans, and service obligations made in exchange for financial assistance, should be fulfilled. There should be mechanisms to assist physicians who are experiencing hardship in meeting these obligations.
10. Our AMA supports the expansion and increase of medical student and physician benefits under Public Service Loan Forgiveness.

11. Our AMA opposes any stipulations in loan repayment programs that place greater burdens upon married couples than for similarly-situated couples who are cohabitating.

CME Rep. 13, A-06; Reaffirmation, I-06; Reaffirmation, I-07; Reaffirmation, I-08; Reaffirmed:
Reaffirmation, I-15

Long-Term Solutions to Medical Student Debt D-305.975
Our AMA will: (1) encourage medical schools and state medical societies to consider the creation of self-managed, low-interest loan programs for medical students, and collect and disseminate information on such programs; (2) advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas; (3) work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment; (4) collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided; and (5) encourage the National Health Services Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.

CME Rep. 3, I-04; Reaffirmation I-06; Appended: Res. 321, A-12; Reaffirmation A-13; Modified:
CCB/CLRPD Rep. 2, A-14; Reaffirmation I-14

Mechanisms to Reduce Medical Student Debt D-305.978
(1) take an active advocacy role during the upcoming reauthorization of the Higher Education Act and other pending legislation, to achieve the following goals: (a) eliminating the single holder rule, (b) making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training, (c) retaining the option of loan forbearance for residents ineligible for loan deferment, (d) including, explicitly, dependent care expenses in the definition of the "cost of attendance," (e) including room and board expenses in the definition of tax-exempt scholarship income, (f) continuing the loan consolidation program, including the ability to "lock in" a fixed interest rate, and (g) adding the ability to refinance Federal Consolidation Loans;

(2) continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases;

(3) encourage members of the Federation to develop or enhance financial aid opportunities for medical students;
(4) continue to monitor the availability of financial aid opportunities and financial planning/debt management counseling at medical schools, and share innovative approaches with the medical education community;

(5) continue to collect and disseminate information to assist members of the Federation (state medical societies and specialty societies) and medical schools to establish or expand financial aid programs; and

(6) continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students.

CME Rep. 10, A-04; Reaffirmation I-08

Access to Confidential Health Services for Medical Students and Physicians H-295.858

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
   A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees’ grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
   B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
   C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
   D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.

3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
   A. be available to all medical students on an opt-out basis;
   B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.

4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.

5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education. CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17

Medical School Financing, Tuition, and Student Debt D-305.993

1. The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of developing 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 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.

8. Our AMA will advocate against putting a monetary cap on federal loan forgiveness programs.

9. Our AMA will: (a) advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; (b) work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be at least equal to the principal amount borrowed; and (c) ask the United States Department of Education to include all terms of Public Service Loan Forgiveness in the contractual obligations of the Master Promissory Note.

10. Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to require programs to include within the terms, conditions, and benefits of appointment to the program (which must be provided to applicants invited to interview, as per ACGME Institutional Requirements) information regarding the Public Service Loan Forgiveness (PSLF) program qualifying status of the employer.

11. Our AMA will advocate that the profit status of a physician’s training institution not be a factor for PSLF eligibility.

12. Our AMA encourages medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.

13. Our AMA encourages medical school financial advisors to promote to medical students service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.

14. Our AMA will strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

CME Rep. 2, I-00; Reaffirmation I-03; Reaffirmation I-06; Reaffirmation A-13; Appended: Res. 323, A-14; Appended: Res. 324, A-15; Appended: Res. 318, A-16; Appended: CME Rep. 07, A-17
Loan Forgiveness Program 305.003MSS
AMA-MSS will ask the AMA to support the development of realistic loan forgiveness programs as one means of effectively addressing the urgent financial needs of medical students. AMA Res 84, I-81 Referred; BOT Rep V, A-82 Referred; Reaffirmed: MSS COLRP Rep B, I-95; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Res 3, I-05; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, 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; AMA Res 303, A-17
Adopted as Amended (appended to H-295.858)

Adequate Insurance for Medical Students and Residents 295.027MSS
AMA-MSS will ask the AMA to: (1) urge all medical schools to pay for or offer affordable, policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) urge all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) urge medical schools and residency training programs to pay for or offer affordable health insurance to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) urge carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. AMA Res 252, A-91, Referred; BOT Rep W, I-91; Adopted: H-295.942; 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

Medical Student Access to Comprehensive Mental Health and Substance Abuse Treatment 295.164MSS
AMA-MSS strongly encourages the Association of American Medical Colleges and the Liaison Committee on Medical Education to conduct research into the number of US medical students with mental health and/or substance abuse concerns who either: 1. do not seek treatment due to the cost involved, or 2. have sought treatment, but do not feel that it has been adequate due to yearly visit and dollar limits placed on their care by their insurance plan. MSS Res 3, I-11; Reaffirmed: MSS GC Report A, I-16

Societal Discrepancies in the Disabled Population and Post-Secondary Disability Resource Center Utilization 90.007MSS
AMA-MSS (1) supports educating medical students and health care professionals on the societal discrepancies endured by the disabled population as well as services provided by post-secondary disability resource centers; and (2) will promote utilization of disability resource
centers at the post-secondary level for students who meet the requirements established by those centers. MSS Res 35, I-10; Reaffirmed: MSS GC Rep D, I-15

Novel Mechanism to Reduce Medical Student Debt 305.080MSS
AMA-MSS will ask the AMA to study the feasibility and effectiveness/utility of loan forgiveness programs for the private sector including but not limited to the offering of tax credits and/or benefits to employers who pay the remaining balance of medical school loans when hiring physicians following completion of residency. MSS Res 6, A-15; AMA Res 908, I-15

Reaffirmation Calendar

Medical School Tuition 305.037MSS
The AMA-MSS Governing Council will continue to work with AMA staff to ensure student concerns on indebtedness and medical school tuition are addressed in all health system reform legislation. MSS Sub Res 27, I-93; 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
Resolution 14
(A-18)

Introduced by: Region 4, Lauren Benning, Campbell University School of Osteopathic Medicine, David Tyson, University of Florida College of Medicine, Steven Peretiatko, University of South Florida Morsani College of Medicine, Ian Motie, Florida State University College of Medicine, Benjamin Chadek-Feeley, Oklahoma State University College of Osteopathic Medicine;

Subject: Regulating Front-of-Package Labels on Food Products

Referred to: MSS Reference Committee
(Chair: Celeste Peay)

Whereas, Many front-of-package (FOP) labels on food products feature nutrient claims that suggest or imply that a food has certain nutritional properties related to its content of energy, proteins, fats, carbohydrates, dietary fiber, vitamins, and/or minerals; and

Whereas, FOP labels attract attention, thereby causing consumers to spend less time reading the nutrition facts on the back and side panel of food products; and

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

Whereas, Studies show that children perceive food products with nutrient claims on their FOP label as healthier; and

Whereas, Studies of responses to nutrition-related claims in food advertising have found that consumers over generalize a product's healthfulness based on narrower claims; and

Whereas, Many front-of-package labels (e.g. “Whole Grain” on sugary cereals and “Good Source of Vitamins and Minerals” on toaster pastries) are placed on products that contain high

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amounts of added sugar, meaning they do not comply with the 2015-2020 U.S. Dietary Guidelines’ recommendation that food products contain no more than 10% added sugars by calorie value; and

Whereas, Evidence shows that individuals who consume diets high in refined carbohydrates are at a greater risk of becoming obese, developing diabetes, and dying from a cardiovascular event; and

Whereas, The Food and Drug Administration (FDA) regulates front-of-package claims by enforcing qualifying criteria that food products must meet for use of each individual nutrient claim; and

Whereas, The FDA has no requirement that food products labeled with nutrient claims that can be generalized to imply healthfulness adhere to specific macronutrient limits; and

Whereas, Studies show that negative cues in the form of warning labels are demonstrated to have a greater impact on consumer food choices than positive health claims,

Whereas, Standardized warning labels have been mandated in Chile on food products high in sugar, salt, fat, and calories since 2016; and

Whereas, To avoid having to add warning labels to their products, food companies in Chile have reformulated over 1,500 food products to be lower in sugar, salt, fat, and calories; and

Whereas, Chilean consumers purchase more of the foods without warning labels than they did before implementation of the warning labels; and

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Whereas, Our AMA and AMA-MSS have established support for consumer-level interventions and education about the effects of excessive dietary sugars (H-150.960, H-150.974, H-150.935, H-150.945, D-150.975, D-150.987); and

Whereas, Our AMA and AMA-MSS have established support for the use of warning labels and plain packaging on sugar-sweetened beverages (H-150.927); and therefore be it

RESOLVED, That our AMA support additional FDA criteria that limit the amount of added sugar a food product can contain if it carries any front-of-package label advertising nutritional or health benefits; and be it further

RESOLVED, That our AMA support the use of front-of-package warning labels on foods that contain excess added sugar
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-150.935 Encouraging Healthy Eating Behaviors in Children Through Corporate Responsibility

Our AMA: 1) supports and encourages corporate social responsibility in the use of marketing incentives that promote healthy childhood behaviors, including the consumption of healthy food in accordance with federal guidelines and recommendations; and 2) encourages fast food restaurants to establish competitive pricing between less healthy and more healthy food choices in children's meals

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

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.

D-150.974 Support for Nutrition Label Revision and FDA Review of Added Sugars

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.

H-150.948 Increasing Awareness of Nutrition Information and Ingredient Lists

Our AMA supports federal legislation or rules requiring restaurants, retail food establishments, and vending machine operators that have menu items common to multiple locations, as well as all school and workplace cafeterias, especially those located in health care facilities, to have available for public viewing ingredient lists, nutritional information, and standard nutrition labels for all menu items.

H-150.942 Rating System for Processed Foods

Our AMA supports the concept of a simplified, uniform nutrition rating system to be used in addition to the current food label.

H-150.927 Strategies to Reduce the Consumption of Beverages with Added Sweeteners

Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption, and support evidence-based strategies to reduce the consumption of SSBs, including but not limited to, excise taxes on SSBs, removing options to purchase SSBs in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption, such as controlling portion sizes; limiting options to purchase or access SSBs in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and replacing SSBs with healthier beverage choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage choices for students.

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

H-440.902 Obesity as a Major Health Concern

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of patients with obesity; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat patients affected by obesity.

150.021MSS Accurate Reporting of Fats in Nutritional Labels

AMA-MSS will ask the AMA to urge the FDA to use the most accurate and scientific processes to measure the fat content in foods, particularly trans fats and saturated fats, and that the most accurate fat content information based on these processes be included on food labeling
Whereas, The current 9-1-1 system is primarily built upon an infrastructure that does not uniformly support modern communications technologies including texting, geolocation, and images;¹,² and

Whereas, Current 9-1-1 infrastructure has continuously been shown to be vulnerable to preventable outages and cyberattacks, which have already temporarily left thousands without access to emergency services;³,⁴,⁵ and

Whereas, The Federal Communications Commission (FCC) has already recommended that Congress increase federal incentives to boost state and local 9-1-1 modernization efforts;⁶ and

Whereas, IP-based communication technologies allow the transmission of data over the internet, allowing for increased information (such as text and geolocation) to be obtained by the receiver compared to old circuit-switch communication;⁷ and

Whereas, Congress has failed to nationally incorporate internet protocol (IP)-based technology into existing 9-1-1 infrastructure, which may lead to inaccurate caller location accuracy on calls over wireline in multiple situations;⁸ and

² Next Generation 9-1-1 Advancement Act of 2011, 47 U.S.C §158. (2012)
Whereas, 95% of Americans own at least one cellphone, 77% own at least one smartphone, and over 70% of all 9-1-1 calls are made from cellphones and other handheld devices, and

Whereas, While the IP-based geolocation accuracy of handheld devices averages about 4.9 meters, current U.S. standards merely mandate that 67% of 9-1-1 calls are accurate within range of 50 meters, a standard that has not been updated since 2012; and

Whereas, Increased 9-1-1 response times, due to factors such as imprecise call tracking, can lead to increased morbidity in cardiac arrest; and

Whereas, The Americans with Disabilities Act of 1990 mandates that 9-1-1 services need only receive message-based communication from teletypewriters (TTYs), devices which are distinct and may be incompatible with modern mobile and smartphones, and

Whereas, Approximately 50 million Americans have hearing disabilities, and 7.5 million Americans have difficulty vocalizing words; and

Whereas, The FCC found a majority of those with hearing and speech disabilities have discarded their TTYs in favor of mobile plans with SMS services, leaving millions with these disabilities at risk of not being able to effectively communicate with 9-1-1 operators; and

Whereas, Nationally, 9-1-1 call centers are not mandated to accept SMS messages (text-to-911), meaning that a citizen’s locale may dictate the amount of emergency services they have access to; and

Whereas, The National Association of the Deaf (NAD) and the Hearing Loss Association of America (HLAA) both acknowledge that the existing 9-1-1 infrastructure limits the ability of those with deafness or hearing loss to contact emergency services; and

Whereas, The NAD and HLAA both support continued modernization of 9-1-1 services, including the continued implementation of text-to-911, and

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11 911 service, 47 C.F.R. § 20.18(h) (2012).
Whereas, Our AMA has adopted policy encouraging guidelines that protect against the reallocation of 9-1-1 funding to unrelated programs (H-440.822), but does not currently encourage the continued modernization of 9-1-1 services; therefore be it RESOLVED, That our AMA encourage federal lawmakers to secure increased and consistent funding for the modernization of 9-1-1 infrastructure; and be it further RESOLVED, That our AMA support upgrades of existing 9-1-1 infrastructure to include a national implementation of text-to-911 capability.
Fiscal Note: Significant, 12

Date Received: 04/11/18

RELEVANT AMA AND AMA-MSS POLICY

Accountability of 911 Emergency Services Funding, H-440.822
Our AMA encourages federal guidelines and state legislation that protects against reallocation of 911 funding to unrelated services.
Whereas, Since 2013 there have been over 300 shootings on school campuses in the United States, including 36 instances where a firearm was unintentionally discharged resulting in injury or death, with 15 of those occurring since 2017;¹ and

Whereas, Arkansas, Colorado, Georgia, Idaho, Kansas, Mississippi, Oregon, Texas, Utah, and Wisconsin allow firearms to be carried on college and university campuses in accordance with concealed carry laws,¹⁶ states have completely banned carrying firearms on college and university campuses, and 23 states leave it up to the discretion of the institution;² and

Whereas, All states but New Hampshire prohibit firearms on K-12 campuses, however, at least 19 states have statutes allowing anyone who has permission from the school authority to carry a firearm at K-12 schools, and 5 other states allow any concealed carry license holders to carry firearms at K-12 schools;³ and

Whereas, Despite the passage of the Gun-Free School Zones Act of 1990 that prohibits possession of firearms on campuses that provide primary or secondary education, there are gaps within this law that allow for certain individuals to possess firearms on campuses including individuals licensed by a state or locality, individuals that are part of a program approved by the school, or individuals that have a contract with a school;⁴ and

Whereas, Research shows that only 12% of mass shootings that involved six or more victims in the United States from 1966 to 2016 were in "gun-free zones" and only 5% occurred in places where civilian gun possession was prohibited;⁵ and

Whereas, Research shows that weapons legally carried by civilians do not decrease the number of mass shooting events or the average number of persons harmed in these events;⁵ and

Whereas, According to FBI data on active shooter events between 2000 and 2013, only 3% were stopped by a civilian with a firearm, while 13% were stopped by unarmed civilians and 56% ended on the shooter’s initiative through methods such as suicide or fleeing; and

Whereas, The Trump administration recently released a proposal to provide some school personnel with firearms training, and multiple state legislatures are attempting to pass legislation that would allow for the capability and funding to arm trained teachers in classrooms, and

Whereas, 46% of teachers in a 2014 national survey reported high daily stress during the school year, which is among the highest of all occupational groups and worse than even physicians, with a key predictor of stress being continued high demand on the job resulting in greater burnout and turnover rates; and

Whereas, A recent poll found that 73% of the teachers polled were opposed to arming staff members in schools, and 82% would not apply for the ability to carry guns in schools, even if given the opportunity, due to fear that they will be burdened with additional responsibilities outside of their current role and the risk of needlessly subjecting students and other staff to danger; and

Whereas, Providing training, concealed carry licenses, and firearms to teachers and staff would pose a large financial burden on the country, estimated to cost up to $1 billion to arm 20% of the teachers in America; and

Whereas, The National Association of School Resource Officers issued a statement opposing the arming of teachers because law enforcement officers responding to an incident may be unable to distinguish between the assailant and other armed persons not in uniform; and

Whereas, Increased prevalence of firearms on campuses could increase the potential for access to weapons by unauthorized users and individuals intending to do harm, and may also

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induce a sense of overconfidence when responding to a crisis thus increasing the likelihood for harm;\textsuperscript{15} and

Whereas, Children who experience violence are at increased risk of suicidal ideation, substance abuse, and interpersonal violence, in addition to increased risk for development of mental illness;\textsuperscript{16,17} and

Whereas, Minority students may be disproportionately affected by an increased number of armed school personnel because studies have shown the role that implicit bias plays in school discipline disparities, and while black students represent 16\% of student enrollment, they represent 27\% of students referred to law enforcement and 31\% of students subjected to a school-related arrest;\textsuperscript{18,19} therefore be it

RESOLVED, That our AMA oppose legislation and policies that would increase the presence of firearms on school campuses through methods including but not limited to programs that arm teachers and other non-security school staff.


RELEVANT AMA AND AMA-MSS POLICY

AMA Campaign to Reduce Firearm Deaths H-145.988
The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths; (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible; (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested
stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of the AMA to: (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 18;
(c) the imposition of significant licensing fees for firearms dealers;
(d) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
(e) mandatory destruction of any weapons obtained in local buy-back programs.
(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.

Prevention of Unintentional Shooting Deaths Among Children H-145.979

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

Prevention of Firearm Accidents in Children H-145.990

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

Gun Regulation H-145.999
Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

**Gun Violence as a Public Health Crisis D-145.995**
Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

**Guns in School Settings H-60.947**
Our AMA recommends: (1) all children who take guns or other weapons to school should receive an evaluation by a psychiatrist or an appropriately trained mental health professional; and (2) that children who are determined by such evaluation to have a mental illness should receive appropriate treatment.

**School Violence H-145.983**
The AMA encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property.

**Need for Adequate Training of Teachers to Identify Potentially Dangerous Children and the Provision of Adequate Insurance Coverage to Provide for their Treatment H-60.946**
Our AMA: (1) supports teacher education initiatives to better enable them to identify children at risk for psychiatric illnesses, substance abuse, and potentially dangerous behaviors; and (2) reaffirms its support for parity of coverage for mental illness.

**Gun Safety Counseling in Undergraduate Medical Education 145.011MSS**
AMA-MSS will ask the AMA to (1) advocate for the inclusion of strategies for counseling patients on safe gun storage and use in undergraduate medical education; (2) add additional language to AMA Policy H-145.976 prohibiting limitations on the ability of medical students to discuss firearms with patients; and (3) advocate that the Association of American Medical Colleges, Agency for Health, Research and Quality, and other relevant professional medical societies develop gun safety counseling modules to be used in undergraduate medical education.

**Handgun Violence 145.001MSS**
The AMA-MSS recognizes that handgun violence and accidents represent a significant public health hazard, and supports the following methods of addressing this hazard: (1) strict federal regulation of the manufacture, sale, importation, distribution, and licensing of handguns and their component parts, including a mandatory 7-day waiting period and police background check for all handgun purchases; (2) supports the taxation of handgun and handgun ammunition sales to be used to help cover medical bills for the victims of handgun violence and to fund public education on the prevention of violence; and (3) educational programs that can demonstrate a reduction in the deaths and injuries caused by handguns.

**Preventing Fire-Arm Related Injury and Morbidity in Youth 145.014MSS**
AMA-MSS will ask the AMA to collaborate with firearms owners and training organizations to develop and distribute firearm safety materials that are appropriate for the clinical setting.
Hospital Workplace and Patient Safety and Weapons 365.004MSS

(1) AMA-MSS supports policies which restrict guns and Tasers in civilian healthcare delivery settings and (2) AMA-MSS supports comprehensive training of security personnel that focus on patient safety and empathy.
Whereas, The FY2019 budget proposes to modify the traditional delivery of Supplemental Nutrition Assistance Program (SNAP) benefits, which could affect over 45 million low-income Americans who receive SNAP benefits;¹ and

Whereas, The budget proposal would potentially result in the delivery of USDA food packages (Harvest Boxes) with pre-selected, shelf-stable milk, cereals, beans and canned fruit and vegetables, as well as meat, poultry or fish; and

Whereas, The USDA previously attempted to provide food packages to Native Americans who live in food deserts, but analysis of the packages based on 2010 Healthy Eating Index shows that packages, which included similar items as the proposed USDA food packages, did not show sufficient nutritional value and that shelf stable diet of canned and powdered food was associated with increased risk of Type 2 diabetes and obesity;² and

Whereas, The total amount of SNAP benefit would remain the same, the portion of benefits allocated for food packages (Harvest Boxes) would be detracted from the currently allocated portion of SNAP Electronic Benefit Transfer (EBT) benefits, decreasing EBT benefits to approximately 50 percent of current benefits, which reduces choice among participants and overstepping an educational component ³and

Whereas, The budget proposal would eliminate funding towards incentives to purchase healthy foods and SNAP’s nutrition education program, including the Food Insecurity and Nutrition Incentive grant program (FINI), which was established in 2014 after the Healthy Incentives Pilot (HIP) program; ⁴and,

Whereas, Results from HIP program authorized in 2008, has shown that providing a credit of 30 cents for every SNAP dollar spent on fruits and vegetables increased purchases of those items by 26%; however, currently reach less than 5% of SNAP participants.\(^5\) and.

Whereas, The proposed budget will cut eligibility for about 4 million people including the elderly, unemployed, and employed low-income individuals, which will increase risk of lack of food security among these vulnerable populations;\(^6\)\(^,\)\(^7\) and.

Whereas, A prospective study found that individuals participating in SNAP exhibited higher total obesity as well as cardiovascular disease and diabetes related mortality than both SNAP-eligible nonparticipants and SNAP-ineligible individuals even though SNAP participants were more likely than SNAP-eligible nonparticipants to have health insurance;\(^8\)

Whereas, Literature reviews show that educational programs have a positive influence on improving diet and health-related outcomes, in some cases up to 54 percent in one year, and recommend improved reimbursement for community-based health education;\(^9\)\(^,\)\(^10\)\(^,\)\(^11\)\(^,\)\(^12\) therefore be it

RESOLVED, That our AMA amend Policy H-150.937, Improvements to Supplemental Nutrition Programs, by addition as follows:

Improvements to Supplemental Nutrition Programs, H-150.937

1. Our AMA supports: (a) 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; (b) 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 (c) 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.

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\(^12\) Guenther, Patricia M., PhD, RD, Luick BR, PhD. Improved Overall Quality of Diets Reported by Expanded Food and Nutrition Education Program Participants in the Mountain Region. Journal of Nutrition Education and Behavior. 2015;47:421-426.e1.
naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.

3. Our AMA will request that the federal government support nutritional education programs for SNAP recipients to (a) augment SNAP goals to improve nutrition among low-income populations, (b) improve cost-effectiveness of SNAP incentive program, and (c) reduce health disparities among SNAP participants and SNAP-eligible nonparticipants.

4. Our AMA advocates for support of research into the most effective measures to improve the nutritional landscape of Supplemental Nutrition Assistance Program beneficiaries, especially in regard to pre-packaged food distributions.

Fiscal Note: Significant, 12

Date Received: 4/11/2018

RELEVANT AMA AND AMA-MSS POLICY

National Nutritional Guidelines for Food Banks and Pantries H-150.930

Our AMA: (1) supports the use of existing national nutritional guidelines for food banks and food pantries and (2) will promote sustainable sourcing of healthier food options and the dissemination of user-friendly resources and education on healthier eating for food banks and food pantries.

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 dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol.

Basic Courses in Nutrition H-150.995
Our AMA encourages effective education in nutrition at the undergraduate, graduate, and postgraduate levels.

Payment for Nutrition Support Services H-150.931
Our AMA recognizes the value of nutrition support teams services and their role in positive patient outcomes and supports payment for the provision of their services.

Dangerous Health and Diet Books H-150.975
The AMA supports study of effective and appropriate ways in which to educate physicians and the American public about the dangers of various diets and health fads.

Nutrition Education H-150.996
Our AMA recommends the teaching of adequate nutrition courses in elementary and high schools.

**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.

**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.

**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.

**Programs to Combat Food Deserts: AMA-MSS will ask the AMA to amend policy D-150.978 by insertion and deletion as follows D-150.978 Sustainable Food 150.026MSS**

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.

**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.

**Food Stamp Incentive Program 150.018MSS**

AMA-MSS will ask the AMA to support legislation to provide a meaningful increase in the value of food stamps when used to purchase fruits and vegetables.

**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.

**Nutrition Education for Parents of School Aged Children 170.012MSS**
AMA-MSS encourages the development of informational nutrition programs to be implemented through the public school system and methods, such as public service announcements or community awareness campaigns, with the goal to educate parents about healthy lifestyles in an effort to prevent and reduce the prevalence of overweight and obesity in children and adolescents.

**Nutrition Counseling for Pregnant and Recent Post-Partum Patients 420.003MSS**

AMA-MSS will ask the AMA to (1) support physician referrals of pregnant and recent post-partum patients to registered dietitians for nutrition counseling; and (2) advocate for the extension of health insurance coverage to registered dietician visits for all pregnant and recent post-partum patients.
Resolution: 18

(A-18)

Introduced by: Neha Anand, Lucy Nam, Caroline Plott, Nicholas Siegel, Brian Lo, Bo Shiu Lai, Lydia Adnane, Neel Koyawala, Pauline Huynh, Ved Tanavde, Johns Hopkins School of Medicine; Arjun Kumar, New York College of Osteopathic Medicine

Subject: Increasing the legal age of purchasing ammunition and firearms from 18 to 21

Referred to: MSS Reference Committee
(Celeste Peay, Chair)

Whereas, Existing AMA-policy states “gun violence represents a public health crisis which requires a comprehensive public health response and solution” (D-145.995); and

Whereas, Current federal law limits the purchase of handguns to age 21 and purchase of long guns to age 18 from a licensed firearms dealer, but unlicensed persons may sell a long gun to a person of any age and handguns to individuals 18 and older;¹ and

Whereas, Federal law and laws in 38 states allow 18- to 20-year-olds to legally possess handguns from unlicensed sellers, such as online retailers and sellers at gun shows;² and

Whereas, Adolescents are predisposed to risk-taking and impulsive behaviors as a result of both social pressure and physiological changes, making youths between 18 and 20 years old more likely to commit homicide than any other age-specific cohort³,⁴,⁵ with homicide offending rates rising sharply at age 18 and peak at age 20;⁶ and

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¹ Minimum Age to Purchase & Possess, Giffords Law Center for Gun Violence. http://lawcenter.giffords.org/gun-laws/policy-areas/who-can-have-a-gun/minimum-age/#federal Accessed 22 March 2018


³ Ibid


Whereas, All 50 states have established 21 as the minimum legal age for consumption of alcoholic beverages due to evidence of heightened risk-taking in adolescence and to protect youth and the public from alcohol abuse;\(^7\)\(^8\) and

Whereas, Homicide and suicide are the second and third leading causes of death behind motor vehicle accidents in people ages 15-24 with the main cause within each category being discharge of a firearm;\(^9\) and

Whereas, Examination of gun offenders incarcerated in the 13 states with the weakest standards for legal firearm ownership found that the largest group of offenders were between 18 and 20 years of age and that they would have been prohibited in states with stricter laws for firearm ownership;\(^10\) and

Whereas, 12 states and the District of Columbia currently have laws that impose a minimum age of 21 for all handgun sales, from licensed or unlicensed sellers;\(^11\) and

Whereas, In an unadjusted Wilcoxon rank sum test of the rate of gun deaths in each US state in 2016, there was a significantly lower gun death rate in states which had a law requiring an individual purchasing a gun to be 21 or older compared to states allowing purchase of handguns by individuals under 21 (\(p=4.02 \times 10^{-5}\));\(^12\)\(^13\)\(^14\) and

Whereas, In 2015, among “Crime Against Person” offenders who used a firearm, offenders ages 18-20 (our target cohort) constituted the second largest cohort (11.5%). Offenders ages 19-24 and 25-29 were the largest cohort (13.0%, tied), while offenders ages 30-34 constituted the third largest cohort (8.2%);\(^15\) and

Whereas, In 2015 Illinois, a state that imposes strict gun laws, reported a fourth of offenders from our target cohort (252) compared to Wisconsin’s reported offenders (1008);\(^1\)\(^17\) and

\(^10\) Vittes KA et al. Legal status and source of offenders’ firearms in states with the least stringent criteria for gun ownership. *Injury Prevention.* 2012.
\(^15\) Easy Access to NIBRS Victims (EZANIBRS) https://www.ojjdp.gov/ojstatbb/ezanibrsdv/
Whereas, from 2001 to 2015, Massachusetts, a state that imposes strict gun laws, reported a ninth of offenders from our target cohort (2629) compared to Tennessee’s reported offenders (23672);\textsuperscript{1,16,17} and

Whereas, Companies such as Dick’s Sporting Goods, LL Bean, and Walmart changed their age of firearm purchase to 21 in 2018;\textsuperscript{18} and

Whereas, Over 80% of the public supports increasing the age of being able to purchase an assault-weapon or gun to 21 years old;\textsuperscript{19} and

Whereas, The Age 21 Act, introduced to the Senate on February 28th, 2018, prohibits the purchase of certain firearms by individuals under the age of 21;\textsuperscript{20} and

Whereas, Existing AMA policy supports “bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 18” (H-145.985); therefore be it

RESOLVED, That our AMA amend policy H-145.985 by addition and deletion to read as follows:

It is the policy of the AMA to: (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:

(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;

(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 18- 21 and bans of purchases of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21

(c) the imposition of significant licensing fees for firearms dealers;

(d) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and

(e) mandatory destruction of any weapons obtained in local buy-back programs.

\textsuperscript{16} Massachusetts NIBRS \url{https://masscrime.chs.state.ma.us/public/Browse/browsetables.aspx}

\textsuperscript{17} Tennessee NIBRS \url{https://crimeinsight.tbi.tn.gov/public/Browse/browsetables.aspx}


Relevant AMA and AMA-MSS Policy:

Prevention of Unintentional Shooting Deaths Among Children H-145.979
Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of “reasonable measures,” be determined by the individual constituencies affected by the law.

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths; (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible; (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

Ban on Handguns and Automatic Repeating Weapons H-145.985
It is the policy of the AMA to: (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to: (a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and
increases in the minimum pressure required to pull triggers;  
(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 18;  
(c) the imposition of significant licensing fees for firearms dealers;  
(d) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and  
(e) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.

(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.

Gun Safety H-145.978
Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed.

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports:  
a) federal and state research on firearm-related injuries and deaths;  
b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy;  
c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety;  
d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes;  
e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes;  
f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and  
g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
**Gun Violence as a Public Health Crisis D-145.995**
Our AMA:
(1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and
(2) will actively lobby Congress to lift the gun violence research ban.

**Physicians and the Public Health Issues of Gun Safety D-145.997**
Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

**Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns H-145.989**
It is the policy of the AMA to encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the safe use of as well as the dangers inherent in the unsafe use of nonpowder (gas-loaded/spring-loaded) guns.

**Guns in School Settings H-60.947**
Our AMA recommends:
(1) all children who take guns or other weapons to school should receive an evaluation by a psychiatrist or an appropriately trained mental health professional; and (2) that children who are determined by such evaluation to have a mental illness should receive appropriate treatment.

**Guns in Hospitals H-215.977**
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

Gun Regulation H-145.999
Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

AMA Campaign to Reduce Firearm Deaths H-145.988
The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.
Waiting Period Before Gun Purchase H-145.992

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Firearm Availability H-145.996
Our AMA:
(1) Advocates a waiting period and background check for all firearm purchasers;
(2) encourages legislation that enforces a waiting period and background check for all firearm 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.

Waiting Periods for Firearm Purchases H-145.991
The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

AMA-MSS:
170.001MSS Prevention & Health Education: "AMA-MSS supports the following principles: (1) Health education AMA-MSS Digest of Policy Actions/ 41 should be a required part of primary and secondary education; (2) Private industry should be encouraged to provide preventative 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.

145.001MSS Handgun Violence: The AMA-MSS recognizes that handgun violence and accidents represent a significant public health hazard, and supports the following methods of addressing this hazard: (1) strict federal regulation of the manufacture, sale, importation, distribution, and licensing of handguns and their component parts, including a mandatory 7-day waiting period and police background check for all handgun purchases; (2) supports the taxation of handgun and handgun ammunition sales to be used to help cover medical bills for the victims of handgun violence and to fund public education on the prevention of violence; and (3) educational programs that can demonstrate a reduction in the deaths and injuries caused by handguns.
AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 19
(A-18)

Introduced by: Region 5; Tabitha Moses, Aria Bassiri, Lara Fahmy, Robert Grenn, Melanie Hartenian, Viktoria Mladenovik, Lauren Newhouse, Deepi Shanbhag, Amitosh Singh; Wayne State University School of Medicine, Courtney Collins; University of Kentucky College of Medicine, Shiri Nawrocki; Rutgers-Robert Wood Johnson Medical School, Sophia Yang; University of California Irvine School of Medicine, Sophie Chung; Yale School of Medicine, Michelle Djohan; University of Toledo College of Medicine, Angie Wan; Case Western Reserve University School of Medicine

Subject: Support Offering HIV Post Exposure Prophylaxis To All Survivors of Sexual Assault

Referred to: MSS Reference Committee (Celeste Peay, Chair)

Whereas, 19.3% of women and 1.7% of men in the United States report being raped during their lifetime, and 1.8 per 1000 children have been sexually abused;¹ and

Whereas, The Centers for Disease Control (CDC) estimates the risk of contracting HIV from a known positive person through consensual vaginal intercourse at 0.1%–0.2% and anal intercourse at 0.5%–3%, and this risk may increase during sexual assault due to injuries sustained by the individual;²,³ and

Whereas, Post-Exposure Prophylaxis (PEP) is antiretroviral medication (ART) taken within 72 hours of HIV exposure to prevent infection and is extremely effective at preventing seroconversion after occupational and non-occupational HIV exposure;⁴,⁵,⁶,⁷,⁸,⁹,¹⁰ and

Whereas, Current CDC guidelines indicate that persons experiencing nonoccupational exposure to HIV should be offered PEP even if the HIV status of the exposure is unknown, if the exposure

occurred within 72 hours and the means of exposure would lead to a high likelihood of HIV contraction in the exposed;\textsuperscript{11,12} and

Whereas, Hospital emergency departments (EDs) typically serve as the primary point of care for survivors of sexual assault, accounting for approximately 65,000–90,000 emergency department visits per year;\textsuperscript{13} and

Whereas, There is no national consensus on emergency medicine residents’ education of sexual assault examinations, which results in various approaches regarding the care of survivors of sexual assaults; furthermore, their care in emergency departments is suboptimal (e.g. one study found that only 17.4% of US hospitals provided comprehensive services to survivors of sexual assaults);\textsuperscript{13,14,15,16,17} and

Whereas, Only 14.5% of assault survivors were offered PEP, and only 8.5% of uninsured assault survivors were offered PEP in a 2009 survey of 117 Los Angeles Emergency Departments;\textsuperscript{18} and

Whereas, A 2018 meta-analysis found that the pooled mean of individuals who were sexually assaulted and offered PEP at studied emergency departments was 55.9%;\textsuperscript{19} and

Whereas, A qualitative study in 2016 of sexual assault patients found that physicians neglecting to offer PEP is a major barrier to patient access, disproportionately affecting those who are homeless or uninsured;\textsuperscript{11,20} and

Whereas, The same study indicated that the physicians neglected to offer PEP or they provided incorrect counseling due to a lack of knowledge about state or national PEP guidelines and a 2013 study found 20% of emergency physicians were not aware CDC PEP guidelines;\textsuperscript{20,21} and

Whereas, The cost of PEP is between $600-$1000, and persons prescribed PEP after sexual assault can be reimbursed for medications and clinical care costs through state Crime Victim’s Compensation Programs funded by the U.S. Department of Justice;\textsuperscript{22,23,24} and


\textsuperscript{16} Monika K Goyal et al., “Enhancing the Emergency Department Approach to Pediatric Sexual Assault Care: Implementation of a Pediatric Sexual Assault Response Team Program,” Pediatric Emergency Care 29, no. 9 (September 2013): 969–73, doi:10.1097/PEC.0b013e3182a21a0d.

\textsuperscript{17} R. C. Merchant et al., “Compliance in Rhode Island Emergency Departments With American Academy of Pediatrics Recommendations for Adolescent Sexual Assaults,” PEDIATRICS 121, no. 6 (June 1, 2008): e1660–67, doi:10.1542/peds.2007-3100

\textsuperscript{18} Raphael J. Landovitz, Kory B. Combs, and Judith S. Currier, “Availability of HIV Postexposure Prophylaxis Services in Los Angeles County,” Clinical Infectious Diseases 48, no. 11 (June 1, 2009): 1624–27, doi:10.1086/598976


Whereas, The estimated lifetime cost for HIV treatment was $367,134 in 2009 and $379,668 in 2010, and the estimated medical cost saved by preventing one HIV infection is $229,800;\textsuperscript{25,26} and

Whereas, Many living with HIV may find it challenging to perform daily tasks, participate in moderate physical activities, or have the energy to engage in an active social life;\textsuperscript{27} therefore be it

RESOLVED, That our AMA advocate for education of physicians about the effective use of Post-Exposure Prophylaxis for HIV and the US PEP Clinical Practice Guidelines; and be it further

RESOLVED, That our AMA support increased public education about the effective use of Post-Exposure Prophylaxis for HIV; and be it further

RESOLVED, That our AMA-MSS will ask the AMA to amend policy H-20.900 by insertion as follows:

HIV, Sexual Assault, and Violence (H-20.900)

Our AMA believes that HIV testing and Post-Exposure Prophylaxis (PEP) 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.

Fiscal Note: Significant, 12

Date Received: 04/11/18

RELEVANT AMA POLICY:
Routine Universal Screening for HIV (8.1)

Physicians’ primary ethical obligation is to their individual patients. However, physicians also have a long-recognized responsibility to participate in activities to protect and promote the health of the public. Routine universal screening of adult patients for HIV helps promote the welfare of individual patients, avoid injury to third parties, and protect public health.

Medical and social advances have enhanced the benefits of knowing one’s HIV status and at the same time have minimized the need for specific written informed consent prior to HIV testing. Nonetheless, the ethical tenets of respect for autonomy and informed consent require that physicians continue to seek patients’ informed consent, including informed refusal of HIV testing.

To protect the welfare and interests of individual patients and fulfill their public health obligations in the context of HIV, physicians should:


(a) Support routine, universal screening of adult patients for HIV with opt-out provisions.
(b) Make efforts to persuade reluctant patients to be screened, including explaining potential benefits to the patient and to the patient’s close contacts.
(c) Continue to uphold respect for autonomy by respecting a patient’s informed decision to opt out.
(d) Test patients without prior consent only in limited cases in which the harms to individual autonomy are offset by significant benefits to known third parties, such as testing to protect occupationally exposed health care professionals or patients.
(e) Work to ensure that patients who are identified as HIV positive receive appropriate follow-up care and counseling.
(f) Attempt to persuade patients who are identified as HIV positive to cease endangering others.
(g) Be aware of and adhere to state and local guidelines regarding public health reporting and disclosure of HIV status when a patient who is identified as HIV positive poses significant risk of infecting an identifiable third party. The doctor may, if permitted, notify the endangered third party without revealing the identity of the source person.
(h) Safeguard the confidentiality of patient information to the greatest extent possible when required to report HIV status.

Sexual Assault Survivor Services (H-80.998)

Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.

HIV, Sexual Assault, and Violence (H-20.900)

Our AMA believes that HIV testing should be offered to all victims of sexual assault, that these victims should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained.

Access to Emergency Contraception (H-75.985)

It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians’ offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.

HIV Postexposure Prophylaxis for Medical Students During Electives Abroad (D-295.970)

Our AMA: (1) recommends that US medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV prophylaxis; and (2) encourages medical schools to provide information to medical students regarding the potential health risks of completing a medical rotation abroad, and on the appropriate precautions to take to minimize such risks.
Pre-Exposure Prophylaxis (PrEP) for HIV (H-20.895)

1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.

RELEVANT AMA-MSS POLICY:
515.010MSS Sexual Assault Survivors’ Rights:
AMA-MSS will ask that our AMA (1) advocate for the legal protection of sexual assault survivors’ rights and will work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (i) receive a medical forensic examination free of charge, which includes but is not be limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (ii) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (iii) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (iv) be informed of these rights and the policies governing the sexual assault evidence kit; and (2) collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016. (MSS Res 21, A-17)

AMA-MSS Statements of Support for HOD Policies
(MSS Res 2, I-07) Decreasing the Spread of HIV/AIDS in the United States: The MSS formally establishes support for the following HOD policy: D-20.992 Routine HIV Screening Our AMA: (1) supports HIV screening policies which include: (a) routine HIV screening of adolescents and adults ages 13-64 and sexually active adults over 65, (b) patients receive an HIV test as a part of General Medical Consent for medical care with option to specifically decline the test, and (c) patients who test positive for HIV receive prompt counseling and treatment as a vital part of screening; (2) supports that the frequency of repeat HIV screening be determined based on physician clinical judgment and consideration of identified risks and prevalent community experience; (3) supports the Centers for Disease Control and Prevention’s (CDC) 2006 Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings; (4) will continue to work with the CDC to implement the revised recommendations for HIV testing of adults, adolescents and pregnant women in health care settings, including exploring the publication of a guide on the use of rapid HIV testing in primary care settings; (5) will identify legal and funding barriers to the implementation of the CDC’s HIV testing recommendations and develop strategies to overcome these barriers; (6) will publicize its newly adopted HIV screening policies via its existing professional electronic and print publications and to the public via news releases and commentaries to major media outlets; and (7) will formally request all public and private insurance plans to pay the cost of routine HIV screening testing of all insured individuals who receive routine HIV testing in accordance with new recommendations.

170.008MSS Increasing HPV Education
AMA-MSS will ask the AMA to: (1) support specific teaching concerning transmission and sequelae in STD education; and (2) reaffirm a commitment to specific HIV and general STD education. (MSS Sub Res 37, I-98) (Reaffirmed Existing Policy in Lieu of AMA Res 405, A-99) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)
170.017MSS Sexual Violence Education and Prevention in High Schools with Sexual Health Curricula
AMAS will ask that our AMA amend policy H-170.968 by insertion and deletion 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; (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

250.011MSS Low Cost Drugs to Poor Countries During Times of Pandemic Health Crisis
AMA-MSS will ask the AMA to: (1) support increased availability of anti-retroviral drugs and drugs to prevent active TB infection to countries where HIV/AIDS is pandemic; (2) encourage pharmaceutical companies to provide low cost medications to countries during times of pandemic health crises; and (3) work with the World Health Organization, UNAID, and similar organizations that provide comprehensive assistance, including health care, to poor countries in an effort to improve public health and national stability. (MSS Amended Res 12, I-01) (AMA Res 402, A-02 Adopted [H250.988]) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11) (Reaffirmed: MSS GC Report A, I-16)
295.107 MSS HIV Post-Exposure Prophylaxis for Medical Students During Electives Abroad
AMA-MSS will ask the AMA to: (1) recommend that U.S. medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV post-exposure prophylaxis, and that the schools assume financial responsibility for providing or obtaining PEP when not otherwise covered; and (2) encourages medical schools to provide information to medical students regarding the potential health risks of completing a medical rotation abroad, and on the appropriate precautions to take to minimize such risks. (MSS Amended Res 13, I-01) (AMA Amended Res 303, A-02 Adopted [D-295.970]) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I16)

20.002 MSS AIDS Education
AMA-MSS: (1) encourages public school instruction, appropriate for a student's age and grade, on the nature of HIV and the prevention of its transmission starting at the earliest age at which health and hygiene are taught; (2) asks the AMA to encourage the training of appropriate school personnel to assure a basic knowledge of the nature of HIV, the prevention of its transmission, the availability of appropriate resources for counseling and referral, and other information that may be appropriate considering the ages and grade levels of pupils. (MSS Sub Res 4, A-87) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)

20.005 MSS Drug Availability
AMA-MSS will ask the AMA, as set forth in its objective of contributing to the betterment of the public health, to: (1) use its resources in cooperation with other health care organizations and agencies to facilitate the distribution of information on drug therapy availability for AIDS; and (2) encourage the FDA to continue to expedite the evaluation of available drugs used in the treatment of AIDS (AMA Res 177, A-88 Adopted as Amended [H-20.922]) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

20.006 MSS AIDS Prevention Through Educational Programs
AMA-MSS will ask the AMA to support attention to language and cultural appropriateness in HIV educational materials and encourage the development of additional materials designed to inform minorities of risk behaviors associated with HIV infection. (AMA Res 121, I-88 Adopted [H-20.904]) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

20.018 MSS Averting Antiretroviral Treatment Rationing in the United States – Strengthening the AIDS Drug Assistance Program
AMA-MSS will ask the AMA to lobby the United States Congress to expand funding to ensure coverage for all current and future qualified individuals for the AIDS Drug Assistance Program. (MSS Res 34, A-11) (Reaffirmed Existing Policy in Lieu of AMA Res 210, I-11) (Reaffirmed: MSS GC Report A, I-16)

20.020 MSS Increase Access to HIV PrEP for At-Risk Individuals
AMA-MSS supports PrEP referral at needle exchange sites. (MSS Res 26, A-17)
Whereas, Under Section 1115 of the Social Security Act, the Secretary of Health and Human Services may approve state waivers for Demonstration projects that are experimental in nature;¹ and

Whereas, Section 1115 Demonstrations allow states to use federal Medicaid funds for costs that would not otherwise be covered,² amounting to approximately one-third (over $100 billion) of Medicaid spending in 2015;³ and

Whereas, States have used these waivers to expand coverage, change delivery systems, alter benefits and cost sharing, modify provider payments, and extend coverage during emergency situations;⁴ and

Whereas, Final evaluations of Medicaid Demonstrations have historically been required by the Centers for Medicare & Medicaid Services only after the final expiration of the Demonstration, rather than at the end of each three-to five-year demonstration cycle;⁵ and

Whereas, Section 1115 Demonstrations may be renewed for multiple three- to five-year demonstration cycles, resulting in Demonstrations running for decades without proper analyses and data reporting;⁶ and

Whereas, an interim report submitted by the state of Massachusetts to the Centers for Medicare & Medicaid Services in 2016 regarding a Demonstration initially approved in 1997 lacked data measuring the effectiveness of changing delivery systems in hospitals receiving Medicaid payments, and also lacked conclusions regarding the effects of these payments, which amounted to nearly $700 million used for the new delivery systems;⁷ and

⁷ Government Accountability Office 2018: 14
Whereas, Massachusetts currently spends approximately 40% of its state budget on Medicaid services, and the Centers for Medicare & Medicaid Services has previously encouraged the state to move to more aggressive accountability measures;

Whereas, In addition to Massachusetts, recent interim evaluations of Medicaid Section 1115 Demonstrations in Arkansas and Arizona lacked important information necessary for proper assessment of Section 1115 Demonstrations; and

Whereas, In ten states, including Arizona, over 75% of the Federal Medicaid Expenditures go towards Section 1115 Demonstrations; and

Whereas, Officials from the Centers for Medicare & Medicaid Services have stated that the agency planned to require appropriate evaluation at the end of each demonstration cycle, but still lacks any written procedures for implementing these requirements; and

Whereas, A study published in January 2018 by the U.S Government Accountability Office showed that state-led evaluations of Demonstrations had limited usefulness for federal decision-making due to the temporal gaps in comprehensive results, and officials from the Centers for Medicare & Medicaid Services acknowledge this fact; and

Whereas, The U.S Government Accountability Office has made the following recommendations to the Centers for Medicare & Medicaid Services: (1) establish written procedures for requiring final evaluation reports at the end of each demonstration cycle, (2) issue criteria for when it will allow limited evaluations of demonstrations, and (3) establish a policy for publicly releasing findings from federal evaluations of demonstrations; therefore be it

RESOLVED, that our AMA encourage the Centers for Medicare & Medicaid Services to establish written procedures that require final evaluation reports of Section 1115 Demonstrations at the end of each demonstration cycle, regardless of renewal status.

Fiscal Note: Significant, 12

Date Received: 04/11/2018

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RELEVANT AMA AND AMA-MSS POLICY:

Medicaid Waivers for Managed Care Demonstration Projects H-290.987
(1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act’s objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package.

Opposition to Medicaid Work Requirements H-290.961
Our AMA opposes work requirements as a criterion for Medicaid eligibility.

Medicaid Expansion Options and Alternatives H-290.966
1. Our AMA encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap.
2. Our AMA encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low income adult populations.
3. Our AMA encourages the Centers for Medicare & Medicaid Services to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults.
4. Our AMA advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid web site.

Advocacy and Studies on ACA Section 1332 (State Innovation Waivers) to Improve States’ Abilities to Innovate and Improve Healthcare Benefits, Access and Affordability 270.030MSS
Our AMA-MSS will ask (1) that our AMA 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 (2) that our AMA study reforms that can be introduced under Section 1332 of the ACA 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 Res 07, A-16)
AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution 21
(A-18)

Introduced by: Region 2; Region 5; Elise Molnar, University of Arizona College of Medicine-Phoenix

Subject: Mitigating the Transportation Barrier for Accessibility of Healthcare for the Medicaid Population

Referred to: MSS Reference Committee (Celeste Peay, Chair)

Whereas, It is estimated that a minimum of 3.6 million people miss or delay appointments and medical care each year due to lack of transportation;¹ and

Whereas, Studies have found that 25% of missed appointments and rescheduling needs were due to lack of access to transportation, and bus users were twice as likely to miss their appointments compared to car users;¹,²,³ and

Whereas, Lack of transportation contributes to missed appointments, problems filling prescriptions, poor management of chronic conditions, and preventable emergency room use, especially for low income households in the United States;⁴ and

Whereas, Increased access to transportation via public transit and ridesharing platforms reduces geographic proximity impact as a barrier to care, and increases the odds of patient show rates to primary care appointments by a factor of 2.57;⁴,⁵ and

Whereas, Approximately 1 in 5 Americans rely on Medicaid for health care coverage, including Non-Emergency Medical Transportation (NEMT), which provides rides to and from medical appointments for qualified individuals;⁶,⁷ and

Whereas, The Government Accountability Office (GAO) identified NEMT as a critical service for Medicaid beneficiaries to access healthcare, and

Whereas, Despite NEMT comprising only about one percent of annual Medicaid funding, the GAO concluded that demand for NEMT is increasing due to increased Medicaid enrollment, and thus increased spending for this service is necessary, and

Whereas, The GAO report also recommended that Centers for Medicare & Medicaid Services provide further guidance to states on how to operate NEMT and respond to the increased demand, and

Whereas, Despite the federal requirement for Medicaid to ensure that its participants have access to basic medical services, each state has its own transportation programs, varying from gasoline vouchers, mileage reimbursements, public transportation passes, or access to transportation broker services, and

Whereas, All but 18 states and the District of Columbia use a type of transportation brokerage model to provide NEMT services, demonstrating a reduction in monthly healthcare costs by 19 percent and increasing access to NEMT through greater efficiency, and

Whereas, In accordance with evidence based recommended treatment plans for chronic conditions, providing NEMT to meet these needs are estimated to save costs of “$333 per person per year for asthma, $2,743 per person per year for congestive heart failure (CHF), and for patients with hypertension NEMT could add one quality adjusted life year for a mere $6.00”; and

Whereas, Despite Medicaid NEMT providing curb-to-curb transportation service, and its availability in all 50 states, it is underutilized, with less than half of eligible Medicaid participants in some states are enrolled in this program, and averaged to only 1.87 trips per Medicaid recipient in 2013, and

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Whereas, Lack of access to NEMT continues to be a barrier, especially in rural areas and for patients who require specialty vehicles such as wheelchair vans;⁸ and

Whereas, At least three states, (Iowa, Indiana, and Kentucky), have received federal waivers to cut Medicaid transportation services, and additional states have waivers pending with the notion that cutting NEMT will decrease escalating costs, and be more comparable to private insurance benefits;⁴,⁶ and

Whereas, The top three reasons to utilize NEMT are for behavioral health services, dialysis, and other preventative services;¹,¹⁸ and

Whereas, Suboptimal transportation to dialysis treatment is associated with worse patient outcomes, including hospitalization, emergency room visits, and intensive care unit admissions;¹⁹ and

Whereas, Medicaid beneficiaries who use NEMT services are more likely to arrive to chronic condition management appointments, for example the management of CHF requires at least 10 visits per year, and individuals utilizing NEMT services are more likely to arrive for appointments (55.81 percent) compared to those who do not use NEMT services (28.22 percent);¹³ therefore be it

RESOLVED, That our AMA-MSS support the research of state allocation of funding to NEMT transportation programs, as deemed by each individual state’s needs, to ensure full and adequate coverage; and be it further

RESOLVED, That our AMA-MSS oppose the authorization of any federally-granted state waivers to cut Medicaid transportation services.

Fiscal Note: Minimal, 4

Date Received: 04/11/18

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.

Medicare’s Ambulance Service Regulations H240.978

1. Our 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 the most appropriate facility based on the patient’s needs and the determination made by physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the onsite evaluation and physician medical direction.

2. Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) to pay emergency medical services providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS defined transport locations.

160.024MSS Transportation and Accessibility to Free Medical Clinics
AMA-MSS will ask the AMA to encourage initiatives that address transportation as a barrier to utilization of those institutions addressing the healthcare needs of the underserved in local communities.
Whereas, The Centers of Disease Control and Prevention (CDC) estimates that 1 in 68 children (14.7 per 1000 eight-year-olds) have been diagnosed with Autism Spectrum Disorder (ASD);\textsuperscript{1,2} and

Whereas, The prevalence of ASD has intensified the demand for effective educational, vocational, and therapeutic support services;\textsuperscript{3,4} and

Whereas, The CDC recommends early screening and diagnosis of ASD to ensure children are connected to necessary support services;\textsuperscript{1,3,5} and

Whereas, Delays exist for children with ASD in reporting developmental concerns, receiving diagnostic evaluations, and connecting them to appropriate support services, which cause high levels of stress for the families caring for them;\textsuperscript{2,5,6,7} and

Whereas, A study by the American Academy of Pediatrics estimated that, in 2011, the total societal costs of caring for children with ASD in the U.S., including healthcare, education, therapy, family-coordinated services, and caregiver time, were estimated at $11.5 billion;\textsuperscript{8} and

Whereas, Children living in medically underserved areas are being diagnosed with ASD at lower rates due to less access to qualified healthcare providers;\textsuperscript{9} and

\textsuperscript{1} Centers for Disease Control and Prevention (2014) “CDC estimates 1 in 68 children has been identified with autism spectrum disorder.” Available at: https://www.cdc.gov/media/releases/2014/p0327-autism-spectrum-disorder.html
\textsuperscript{2} Autism Speaks (2014) “CDC’s new update on autism: what you need to know.” Available at: https://www.autismspeaks.org/blog/2016/04/01/cdc’s-new-update-autism-what-you-need-know
\textsuperscript{3} FPG Child Development Institute at The University of North Carolina at Chapel Hill (2014) “Evidence-Based Practices for Children, Youth, and Young Adults with Autism Spectrum Disorder.” Available at: http://cidd.unc.edu/Registry/Research/Docs/31.pdf
Whereas, The Interagency Autism Coordinating Committee (IACC) of the U.S. Department of Health and Human Services creates an annual Strategic Plan to guide federal agencies and private organizations on ASD research and service priorities, knowledge gaps, and goals;10 and

Whereas, In 2015, 32% of federal funding for ASD research went to Biology Research, while Research on Screening & Diagnosis and Research on Services to improve efficacy and access to evidence-based care received 2 of the smallest allocations (9 and 6%, respectively);10 and

Whereas, The Maternal and Child Health Bureau of the U.S. Health and Resources Services Administration (HRSA) provides funds to states to improve access to care through timely diagnosis, feedback, and entry into coordinated systems for children with ASD;11,12,13 and

Whereas, The Virginia Commonwealth University received HRSA funding in 2013 for ASD Early Systematic Training in Effective Practices (ASD Early STEP), partnering with 20 agencies across Virginia to screen, diagnose, and offer interventional services for 190 families;14,15,16 and

Whereas, In 2016, HRSA awarded funds to 4 projects – The Autism Care Team (ACT) of Delaware, The Wisconsin Care Integration Initiative (WiCI) of Wisconsin, The Autism Project (TAP) of Rhode Island, and the Autism Spectrum Disorders and Other Developmental Disabilities (AS3D) Project of Washington, – to improve state-level integrative care systems for children with ASD in medically underserved areas;11,17,18,19,20,21 and

Whereas, The above 4 projects are building models based on Shared Resources for care coordination, Telemedicine/Telehealth to facilitate cross-system organization and data sharing, and Family Navigation to help families surpass healthcare system barriers;11,17,18,19,20,21 and

16 Virginia Commonwealth University (2015) “ASD Early STEP.” Available at: https://partnership.vcu.edu/ASDearlySTEP/aboutus2.html
Whereas, Funding for ASD Early STEP expired in 2017 and funding for ACT, WiCII, TAP, and AS3D will expire in 2019; and therefore be it,

RESOLVED, That our AMA support research models for screening, diagnosis, and support services for children with ASD; and be it further

RESOLVED, That our AMA advocate for increased funding for research models to ensure that children with ASD receive necessary interventions as early as possible.

Fiscal Note: Significant, 12

Date Received: 04/11/18

Relevant AMA and AMA-MSS Policy:

H-90.969 Early Intervention for Individuals with Developmental Delay
(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.

H-90.968 Medical Care of Persons with Developmental Disabilities

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.

4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.

5. Our AMA recognizes the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community.

6. Our AMA supports efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities.

7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities.

8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities.

9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities.

AMA-MSS 25.002 Transitional Support for Individuals with Autism Spectrum Disorders into Adulthood
AMA-MSS will as our AMA to encourage appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for adults with developmental delays, with the goal of independent function when possible. (MSS Res 6, I-15) (AMA Res 001, A-16 Adopted with Change in Title to “Support Persons with Intellectual Disabilities” []).
AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution 23
(A-18)

Introduced by: Nathanael J. Franks, University of Texas Health San Antonio; Shiri Nawrocki, Rutgers – Robert Wood Johnson Medical School

Subject: Support for Very Low Nicotine Content Cigarettes as Part of the FDA’s Cigarette Nicotine Reduction Plan

Referred to: MSS Reference Committee (Celeste Peay, Chair)

Whereas, The economic cost of smoking is more than $300 billion per year, which includes $170 billion in healthcare costs and more than $156 billion in lost productivity due to premature death and secondhand smoke;¹ and

Whereas, Cigarette smoking leads to more than 480,000 deaths per year in the United States, including more than 41,000 deaths resulting from secondhand smoke exposure. This is approximately one in five deaths annually, or 1,300 deaths every day;² and

Whereas, The mortality rate at any given age is 2 to 3 times higher among cigarette smokers compared to lifetime non-smokers;³ and

Whereas, Cigarette smoking is the leading cause of preventable death and, on average, smokers die 10 years earlier than non-smokers;⁴ and

Whereas, 90% and 99% of cigarette smokers first attempted cigarette smoking before age 18 and 26 respectively,⁵ during which the brain is still reaching full development and may not have mature judgment pathways,⁶ and the users are not fully aware of the addictiveness and lifelong consequences of smoking;⁷ and

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Whereas, Although 70% of adult smokers want to quit, adult smokers must generally attempt 30 or more times before succeeding and are ultimately only 4%-7% successful; and

Whereas, Nicotine addiction is a factor of higher resulting nicotine concentration, quicker delivery, and higher rate of absorption; and

Whereas, Earlier attempts to engineer “light” or “low yield” cigarettes by use of ventilation holes were overcome by compensatory habits of smoking more cigarettes, modifying consumer technique, such as blocking the holes with the mouth or finger, or taking larger or more frequent puffs, which in effect delivered the identical nicotine amount as conventional cigarettes, leading our AMA in H-495.981, Light and Low-Tar Cigarettes, to not support the marketing and use of such cigarettes to decrease smoking addiction; and

Whereas, Conventional U.S. cigarettes generally yield 1.1 to 1.7 mg of nicotine each, certain newer Very LowNicotine Content (VLNC) cigarettes yield only between 0.02-0.07 mg of nicotine per cigarette and cannot be overcome by user modification; and

Whereas, A recent double-blind, parallel, randomized clinical trial demonstrated that the use of VLNC cigarettes significantly reduced dependence on nicotine, the number of cigarettes smoked, and craving during smoking abstinence; and

Whereas, Based upon a 2018 simulation model using empirical evidence and expert opinion comparing implementation of a maximum nicotine level in cigarettes versus the status quo, it is estimated that the U.S. smoking prevalence will drop from 12.8% to 10.8% within the first year and to 1.4% by 2060, avoiding 3 million deaths in tobacco smoking, and saving an additional 33 million youth and adults by year 2100 from becoming smokers that would otherwise become smokers if nothing is implemented; and

Whereas, The FDA has issued an Advanced Notice of Proposed Rulemaking and related actions to reduce smoking rates by limiting nicotine in combustible cigarettes to minimally or non-addictive levels as part of its comprehensive plan on tobacco and nicotine regulation; and

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Whereas, Our AMA reaffirms its position in H-495.988, Regulation of Tabacco Products, that the U.S. Food and Drug Administration’s (FDA) has and should continue to have authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing of tobacco products, including measures to reduce the addictiveness of cigarettes; therefore be it

RESOLVED, That our AMA amends H-495.981, Light and Low-Tar Cigarettes as follows:

Light and Low-Tar Cigarettes H-495.981

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.

However, when prevention and first line cessation methods are not successful, our AMA supports the substitution of traditional cigarettes with Very Low Nicotine Content (VLNC) cigarettes, as defined by the U.S. Food and Drug Administration (FDA), as a step to decrease the addictiveness of cigarettes and thus the prevalence of smoking in our society.
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, unless they meet the criteria and requirements as defined by the FDA.

RELEVANT AMA AND AMA-MSS POLICY

Light and Low-Tar Cigarettes H-495.981
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.

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.

Regulation of Tobacco Products H-495.988
Our AMA: (1) reaffirms its position that all tobacco products are harmful to health, and that there is no such thing as a safe cigarette; (2) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (3) 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; (4) 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; (5) 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; (6) 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; (7) encourages the FDA to assert its authority over the manufacture of tobacco products to reduce their addictive potential at the earliest practical time, with a goal for implementation within 5-10 years; and (8) 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. (CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Appended: Res. 234, A-12)

FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973
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 spokespersons; (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.

Ethyl Alcohol and Nicotine as Addictive Drugs H-30.958
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.

**Tobacco Product Labeling H-495.989**
Our AMA: (1) supports requiring more explicit and effective health warnings, such as graphic warning labels, regarding the use of tobacco (and alcohol) products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco, and ingredients of tobacco products sold in the United States); (2) encourages the Food and Drug Administration, as required under Federal law, to revise its rules to require color graphic warning labels on all cigarette packages depicting the negative health consequences of smoking; (3) supports legislation or regulations that require (a) tobacco companies to accurately label their products indicating nicotine content in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;" and (4) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets.

**Electronic Cigarettes, Vaping, and Health: 2014 Update H-495.972**
1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly. 2. Our AMA encourages further clinical and epidemiological research on e-cigarettes. 3. Our AMA supports education of the public on electronic nicotine delivery systems (ENDS) including e-cigarettes.

**Physician Responsibilities for Tobacco Cessation H-490.917**
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.

**Tobacco Taxes H-495.987**

(1) Our AMA will work for and encourages all levels of the Federation and other interested groups to support efforts, including education and legislation, to pass increased federal, state, and local excise taxes on tobacco in order to discourage tobacco use. (2) An increase in federal, state, and local excise taxes for tobacco should include provisions to make substantial funds available that would be allocated to health care needs and health education, and for the treatment of those who have already been afflicted by tobacco-caused illness, including nicotine dependence, and to support counter-advertising efforts. (3) Our AMA continues to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of tobacco products; and advocates that the added tax revenues obtained as a result of reducing or eliminating the tobacco advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion and health education.

**Support for Non-Addictive Nicotine Content Levels in Cigarettes MSS Res 1, A-13**

The MSS formally establishes support for the following HOD policy: H-495.988 FDA Regulation of Tobacco Products Our AMA: (1) reaffirms its position that all tobacco products are harmful to health, and that there is no such thing as a safe cigarette; (2) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (3) 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; (4) 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; (5) 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; (6) 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; (7) encourages the FDA to assert its authority over the manufacture of tobacco products to reduce their addictive potential at the earliest practical time, with a goal for implementation within 5-10 years; and (8) 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. (CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Appended: Res. 234, A-12)

Tobacco Cessation Counseling 490.015MSS

AMA-MSS will ask the AMA to: (1) urge third party payors and governmental agencies involved in medical care to regard and treat nicotine addiction counseling and/or treatment by physicians as an important and legitimate medical service; and (2) work with the US Public Health Service, particularly the Agency for Health Care Policy and Research, health insurers, and others to develop recommendations for third party payment for the treatment of nicotine addiction. (AMA Amended Res 411, I-92 Adopted [H-490.916]) (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)
AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution 24
A-18

Introduced by: Region 6; Region 5; Jehan Momin, Gillian Naro, Penn State College of Medicine; Cindy Tsui, Eric Hirsch, SUNY Downstate College of Medicine

Subject: Increasing Accessibility to Adult Incontinence Products

Referred to: MSS Reference Committee (Celeste Peay, Chair)

Whereas, Incontinence products are defined as “pads, liners, male guards, belted undergarments, pant systems, pull-up underwear, adult diapers/tabbed briefs, boosters” and other products used to manage involuntary urinary and/or bowel movements;¹ and

Whereas, The Urology Care Foundation estimates that between 25% to 33% of all people in the US suffer some degree of urinary incontinence, with ≥50% of individuals age 65 and older having experienced at minimum mild incontinence;²,³ and

Whereas, Prior studies have cited incontinence as detrimental to quality of life via its impact on relationships, self-esteem, employment, travel, and social activities,⁴,⁵,⁶ and

Whereas, The annual average combined direct medical costs, non-medical costs, and lost productivity per woman due to fecal incontinence is approximately $4110;⁷ and

Whereas, In 2015, the median income of households with members age 65 and older was $38,515;⁷,⁸ and

Whereas, Seniors can expect to spend roughly $1800 dollars annually on adult diapers, and for low-income individuals this expense “can consume over 10 percent of their annual income”;⁴ and

Whereas, The mean minimum tax rate of all states charging sales tax on adult incontinence products is 5.4 percent with a range of 2.9 percent at lowest to 7.25 percent at highest;⁹ and

³ Alameda County Board of Supervisors. Legislative Position Request Form. January 11, 2016.
Whereas, 18 states have already eliminated sales tax on adult incontinence products by classifying them as medical supplies or clothing, exempting them as medical prescriptions, or having no sales tax at all;\textsuperscript{10} and

Whereas, Adult incontinence products are generally considered a qualifying expense for patients utilizing health flexible spending arrangement (health FSA), health reimbursement arrangement (HRA), or health savings account (HSA);\textsuperscript{10} and

Whereas, State Medicaid programs provide disposable incontinence supply benefits with each individual State determining qualifications for and extent of benefits;\textsuperscript{11,12,13} and

Whereas, Medicare Part B does not currently cover adult incontinence supplies or diapers despite previously having done so;\textsuperscript{14} and

Whereas, New Jersey’s 218th Legislature introduced resolution No. 53 asking Congress to enact Medicare Part B coverage for adult incontinence products, stating that “Medicare Part B coverage of incontinence products would greatly alleviate the financial burden that many senior citizens face and would enable them to remain vibrant members of their community living in their own homes”\textsuperscript{,15} and

Whereas, AMA policy H-270.953 recognizes access to feminine hygiene products used for menstruation and other genital-tract secretions as a public health issue and supports the removal of sales tax on all feminine hygiene products; and

Whereas, While AMA-MSS policy 245.021MSS The Diaper Gap recognizes access to children’s diapers as a public health issue, the AMA currently lacks actionable directives that enable identification of and advocacy for solutions to barriers in accessing adult diapers; therefore be it

RESOLVED, That our AMA advocate for legislation that removes sales tax on adult incontinence products; and be it further

RESOLVED, That our AMA encourages Medicare coverage for adult incontinence products.

RELEVANT AMA AND AMA-MSS POLICY:

Tax Exemptions for Feminine Hygiene Products H-270.953
Our AMA supports legislation to remove all sales tax on feminine hygiene products.

The Diaper Gap 245.021 MSS
Our AMA advocates for increased access to affordable diapers through various methods including the elimination of taxation.
Whereas, The American College of Obstetrics and Gynecology and American Society of Anesthesiologists view a mother's demand as reason enough for the introduction of epidural analgesia in labor, provided that no contraindications exist; and

Whereas, Thirteen states, including Ohio, Louisiana, and Nebraska, currently have no explicit policy on a minors’ authority to consent to prenatal care, such as an epidural, choosing a cesarean section, or a procedure to test for chromosomal abnormalities in the fetus; and

Whereas, In 2014 in the U.S., “there were 24.2 births for every 1,000 adolescent females ages 15-19, or 249,078 babies born to females in this age group,” and

Whereas, In Ohio, there were 25.1 births for every 1,000 females, ages 15-19 years in 2014, and there currently is no legal process for emancipation, with the exception of deceased parents, active military service, or marriage, and without a minor consent law, pregnant teens are left vulnerable and unable to consent to care during pregnancy and birth, to any procedures deemed elective; and

Whereas, A thorough review has found no current research on minors’ lack of autonomy during the birthing process, anecdotal evidence provided by an obstetrician at The Ohio State University Wexner Medical Center confirms personally handling these cases, reporting that his patients experience “unnecessary pain” and “just as frequently, there are cases where the mothers intentionally deny their teenage daughters an epidural,” as a form of punishment for becoming pregnant; and

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Whereas, “Compared with mothers aged 20-24 years, adolescent mothers aged 10-19 years had higher risks of eclampsia, puerperal endometritis, systemic infections, low birthweight, preterm delivery, and severe neonatal conditions;” and

Whereas, Teenage mothers are twice as likely to require forceps delivery compared with women over the age of 20, which increases the risk of injury for both mother and baby, postulated to be due to the physical immaturity of the younger mother and fright and lack of cooperation during labor; and

Whereas, Childbirth may be a significant cause of posttraumatic stress disorder (PTSD) in women and a woman’s subjective experience of childbirth is strongly associated with the development of PTSD; and

Whereas, A traumatic birth can negatively impact a mother’s attachment to her child and increase the use of medical services by the mother and child; and

Whereas, For preterm children, negative birth experiences predict a future of negative mother-child interactions and future behavioral and emotional problems for the child; and

Whereas, Mothers who experienced increased pain, exhaustion, and negative feelings during labor had delayed onset of lactation; and

Whereas, Labor epidurals have shown to improve infant outcomes in mothers at high risk for unscheduled cesareans highlighting the necessity of epidurals in certain situations; and

Whereas, The use of epidurals reduces childbirth pain and discomfort, allowing mothers to have a more positive birth experience; and

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Whereas, Epidural labor analgesia is associated with a decreased risk of postpartum depression;\(^{15}\) and

Whereas, Our AMA “supports the development of legislation or other appropriate means to provide access to prenatal care for all women,” (H420.978) we believe there is value in specifying inclusivity of minors, and therefore be it,

RESOLVED, That our AMA advocate for the right of the minor to consent health care services from the prenatal stage through delivery, including but not limited to consenting to an epidural, a cesarean section, and testing for chromosomal abnormalities in the fetus; and be it further

RESOLVED, that our AMA amend existing AMA policy, H-420.978 Access to Prenatal Care, as follows:

Access to Prenatal Care, H-420.978

(1) The AMA supports the development of legislation or other appropriate means to provide access to prenatal care for all women, including minors, with alternative methods of funding, including private payment, third party coverage, and/or government funding, depending of the individual’s economic circumstances. (2) In developing such legislation, the AMA urges that the effect of medical liability in restricting access to prenatal and natal care be taken into account

Fiscal Note: Significant, 12

Date Received: 4/11/2018

**RELEVANT AMA AND AMA-MSS POLICY:**

**Access to Prenatal Care H-420.978**

(1) The AMA supports the development of legislation or other appropriate means to provide access to prenatal care for all women, with alternative methods of funding, including private payment, third party coverage, and/or government funding, depending of the individual’s economic circumstances. (2) In developing such legislation, the AMA urges that the effect of medical liability in restricting access to prenatal and natal care be taken into account.

**2.2.2 Confidential Health Care for Minors**

Physicians who treat minors have an ethical duty to promote the developing autonomy of minor patients by involving children in making decisions about their health care to a degree commensurate with the child’s abilities. A minor’s decision-making capacity depends on many factors, including not only chronological age, but also emotional maturity and the individual’s

medical experience. Physicians also have a responsibility to protect the confidentiality of minor patients, within certain limits.

In some jurisdictions, the law permits minors who are not emancipated to request and receive confidential services relating to contraception, or to pregnancy testing, prenatal care, and delivery services. Similarly, jurisdictions may permit unemancipated minors to request and receive confidential care to prevent, diagnose, or treat sexually transmitted disease, substance use disorders, or mental illness.

When an unemancipated minor requests confidential care and the law does not grant the minor decision-making authority for that care, physicians should:

(a) Inform the patient (and parent or guardian, if present) about circumstances in which the physician is obligated to inform the minor’s parent/guardian, including situations when:

   (i) involving the patient’s parent/guardian is necessary to avert life- or health- threatening harm to the patient;

   (ii) involving the patient’s parent/guardian is necessary to avert serious harm to others;

   (iii) the threat to the patient’s health is significant and the physician has no reason to believe that parental involvement will be detrimental to the patient’s well-being.

(b) Explore the minor patient’s reasons for not involving his or her parents (or guardian) and try to correct misconceptions that may be motivating the patient’s reluctance to involve parents.

(c) Encourage the minor patient to involve his or her parents and offer to facilitate conversation between the patient and the parents.

(d) Inform the patient that despite the physician’s respect for confidentiality the minor patient’s parents/guardians may learn about the request for treatment or testing through other means (e.g., insurance statements).

(e) Protect the confidentiality of information disclosed by the patient during an exam or interview or in counseling unless the patient consents to disclosure or disclosure is required to protect the interests of others, in keeping with ethical and legal guidelines.

(f) Take steps to facilitate a minor patient’s decision about health care services when the patient remains unwilling to involve parents or guardians, so long as the patient has appropriate decision-making capacity in the specific circumstances and the physician believes the decision is in the patient’s best interest. Physicians should be aware that states provide mechanisms for unemancipated minors to receive care without parental involvement under conditions that vary from state to state.

(g) Consult experts when the patient’s decision-making capacity is uncertain.
(h) Inform or refer the patient to alternative confidential services when available if the physician is unwilling to provide services without parental involvement.

Confidential Health Services for Adolescents H-60.965
Our AMA:

(1) reaffirms that confidential care for adolescents is critical to improving their health;

(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;

(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;

(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);

(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;

(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;

(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;

(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and

(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.
Whereas, Restrictive housing, often referred to as “segregation” or “solitary confinement”, is defined as the placement of an inmate in a locked cell for 22 or more hours in a day, with or without a cellmate;\textsuperscript{12} and

Whereas, existing AMA-MSS policy opposes “the use of solitary confinement for juveniles or the mentally ill regardless of circumstance” and “the use of solitary confinement for disciplinary purposes” for all inmates (140.028MSS), but AMA policy only takes a stance against solitary confinement for juveniles (H-60.922); and

Whereas, a resolution that passed in the AMA-MSS at I-17 asks that “our AMA oppose restrictive housing for incarcerated persons with mental illness”, but does not address restrictive housing for adults without mental illness; and

Whereas, A 2015 study estimates that 80,000 to 100,000 inmates, or about 5% of all inmates, are in restrictive housing in federal and state prisons for adults nationwide;\textsuperscript{3} and

Whereas, In a 2015 Bureau of Justice Statistics survey, 18.1% of prison inmates and 17.4% of jail inmates, all in adult facilities, reported having spent time in “disciplinary or administrative segregation or solitary confinement,” in the past 12 months, with higher rates of restrictive housing use among inmates with mental health problems, black inmates, and lesbian, gay, and bisexual inmates;\textsuperscript{4} and

Whereas, Continuous length of stay in restrictive housing varies widely among jurisdictions, with three of ten included in one study reporting that the majority of stays are less than 90 days, and

\textsuperscript{1} American Correctional Association. Restrictive Housing Performance Based Standards. 2016.
\textsuperscript{2} Department of Justice. Report and Recommendations concerning the Use of Restrictive Housing. 2016.
eight of ten reporting that some inmates are placed in restrictive housing for more than 3 years;⁵ and

Whereas, In many correctional systems, inmates can be placed indefinitely in non-disciplinary restrictive housing pending investigation of a suspected rule violation, even if no violation has been identified, often categorized as “administrative” or “investigative” segregation⁶,⁷ and

Whereas, The United Nations Special Rapporteur has stated and reaffirmed that the use of solitary confinement beyond 15 days “constitutes torture or cruel, inhuman or degrading punishment, depending on the circumstances.”⁸,⁹ and

Whereas, Existing AMA policy “opposes torture in any country for any reason” (H-65.981); and

Whereas, The National Commission on Correctional Healthcare, an organization established by the AMA in response to inadequate healthcare in jails, recommends that “prolonged solitary confinement should be eliminated as a means of punishment” and that “solitary confinement should never exceed 15 days.”¹⁰ and

Whereas, A wide body of literature has documented detrimental psychological outcomes and increased suicide rates in inmates exposed to prolonged isolation¹¹,¹²,¹³,¹⁴ and

Whereas, Access to mental health care in restrictive housing varies widely from institution to institution, ranging from none to more than 20 hours per week;¹⁵ and

Whereas, Inmates in restrictive housing have limited contact with family and community members,¹⁶ potentially damaging support networks that are crucial for successful re-entry; and

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⁶ Shames A, Wilcox J, Subramanian, R. Solitary Confinement: Common Misconceptions and Emerging Safe Alternatives. Vera Institute of Justice. 201
⁷ Report and Recommendations Concerning the Use of Restrictive Housing. US Department of Justice.
Whereas, Using data from the Ohio Department of Rehabilitation and Correction, a study found that the length of time spent in solitary confinement does not influence subsequent inmate misconduct;¹⁷ and

Whereas, Mississippi reduced its population in restrictive housing from 1,000 to 150 and instituted new mental health programming during the mid- to late 2000s, resulting in an almost 70% decrease in serious inmate-on-inmate and inmate-on-staff incidents;¹⁸ and

Whereas, In a 2016 US Department of Justice report, the Federal Bureau of Prisons recommended significant reductions in the use of restrictive housing as a form of punishment, including reductions of maximum lengths-of-stay for disciplinary penalties, as well as limitations on the use of pre-adjudication “investigative” segregation;¹⁹ and

Whereas, Many safe alternatives to restrictive housing have been established and put into practice, while research continues on the development of new alternatives;²⁰,²¹ therefore, be it

RESOLVED, That our AMA oppose the use of restrictive housing in adult correctional facilities for disciplinary purposes or pending investigation of a suspected rule violation for more than 15 consecutive days, and be it further

RESOLVED, That our AMA support efforts to ensure that the mental and physical health of all individuals in restrictive housing are regularly monitored by health professionals, and be it further

RESOLVED, That our AMA support the development and use of safe alternatives to restrictive housing in adult correctional facilities.

¹⁹ Report and Recommendations Concerning the Use of Restrictive Housing. US Department of Justice. 2016.
²⁰ Ibid.
Fiscal Note: Minimal, 6

Date Received: 04/11/18

RELEVANT AMA AND AMA-MSS POLICY

AMA
Solitary Confinement of Juveniles in Legal Custody H-60.922
Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.

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.

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.

**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; condemns the persecution of physicians and other health care personnel who treat torture victims.

**AMA-MSS**
**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)

**Reduced Incarceration and Improved Treatment of Individuals with Mental Illness or Illicit Drug Dependence 345.006MSS**
Reduced Incarceration and Improved Treatment of Individuals with Mental Illness or Illicit Drug Dependence: AMA-MSS will ask the AMA to amend policy H-430.989 by insertion and deletion as follows: H-430.989 Disease Prevention and Health Promotion in Correctional Institutions
AMA-MSS Digest of Policy Actions/ 90 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 1. the prevention and control of HIV/AIDS, substance abuse, tuberculosis and hepatitis, 2. the management and treatment of psychiatric disorders such as drug dependence, and 3. a reduction in reincarceration rates related to drug abuse and psychiatric disorders. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers, and drug treatment center staff, and psychiatric care 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 history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs, as well as inpatient or outpatient psychiatric treatment programs, as a sentence or in connection with sentencing.” (MSS Res 30, I-11) (HOD Policy H-430.997 Amended in Lieu of AMA Res 502, A-12) (Reaffirmed: MSS GC Report A, I-16)

**Solitary Confinement 140.028MSS**
Solitary Confinement: That our AMA (1) oppose the use of solitary confinement for juveniles or the mentally ill regardless of circumstance; (2) oppose the use of solitary confinement for disciplinary purposes; and (3) support that isolation for clinical or therapeutic purposes must be
conducted under the recommendation and supervision of a physician. (MSS Res 2, A-14) (AMA Res 3, I-14 Adopted as Amended with Change in Title [H-60.922])
Whereas, More than 3.5 million Americans will experience homelessness at some point in a given year, and 77,486 of these individuals are chronically homeless, and;

Whereas, The AMA supports public policy initiatives pertaining to access to care, particularly for the homeless population (H-160.798, H-345.975, H-185.944), and;

Whereas, The Michigan Commission on Community Action and Economic Opportunity has identified “inability to obtain legal identification” as “a key barrier for people seeking…medical care and participation in essential programs and services that support a healthy and successful life, and;

Whereas, Lack of identification serves as a major barrier for homeless individuals attempting to enroll in Medicaid, with 45.1% of the homeless without photo identification being denied access to Medicaid or medical services, and;

Whereas, It is estimated over 36% of the U.S. population suffers from a severe mental illness or chronic substance abuse, and lack of identification is a barrier to access for drug treatment and rehabilitation programs, and;

Whereas, 43 states allow for pharmacists to require photograph identification from individuals prior to dispensing prescription drugs, and;

Whereas, The National Law Center on Homelessness and Poverty found that 54.1% of homeless individuals were denied housing or shelter due to lack of identification, and;

Whereas, Unsheltered homeless individuals often have poorer health, less access to healthcare, and an increased risk of premature mortality compared to the sheltered homeless, and;

Whereas, Lack of identification can serve as a barrier for homeless individuals who qualify for Supplemental Nutrition Assistance Program (SNAP) benefits to access this service as the application process includes having information such as personal identification verified, and;

Whereas, Recent national surveys have shown that 28% of homeless individuals do not get enough to eat, and 40% report going one or more days without food due to the inability to afford it, yet only 37% of the homeless population received Supplemental Nutrition Assistance Program (SNAP) benefits, and;

Whereas, The AMA supports improving health outcomes and decreasing healthcare costs for the homeless (H-160.903); and;

Whereas, Lack of identification has economic ramifications for the healthcare system in that individuals lacking, or unable to obtain, health insurance are more likely to delay seeking care, present with more severe problems, and increase emergency department utilization, thus increasing healthcare costs, and;


Whereas, The Medicaid application process includes verifying the applicant’s social security number, yet a replacement social security card requires a form of identification such as driver’s license, state-issued non-driver identification card, or U.S. passport\textsuperscript{15,16}, and;

Whereas, The average application fees to obtain a birth certificate and passport in the U.S. are $15.81 and $97, respectively,\textsuperscript{17} and;

Whereas, A national study identified 36% of homeless individuals could not obtain a photo identification because they could not afford it,\textsuperscript{18} and;

Whereas, The state of California has recognized the value of allowing homeless individuals to obtain free photo identification by passing this into law,\textsuperscript{19} while a number of other state legislatures are in the process of addressing this issue as well,\textsuperscript{20,21,22,23} therefore be it

RESOLVED, Our AMA recognize that among the homeless population, a lack of identification card serves as a barrier to accessing medical care as well as fundamental services that support healthy lifestyle; and further be it;

RESOLVED, Our AMA support legislation and policy changes that aim to provide a streamlined and simplified application process for obtaining identification cards that facilitate accessibility to the homeless population; and further be it;

RESOLVED, Our AMA promote legislation changes and policy initiatives focused on providing identification cards to homeless individuals without charge.

Fiscal Note: Moderate, 10

Date Received: 04/11/18

RELEVANT AMA AND AMA-MSS POLICY

The Mentally Ill Homeless H-160.978 - (1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.

Eradicating Homelessness H-160.903 - Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; and (2) supports the appropriate organizations in developing an effective national plan to eradicate homelessness.

Caring for the Poor H-160.961 - (1) Each physician has an obligation to share in providing care to the indigent. The measure of what constitutes an appropriate contribution may vary with circumstances such as community characteristics, geographic location, the nature of the physician’s practice and specialty, and other conditions. All physicians should work to ensure that the needs of the poor in their communities are met. Caring for the poor should become a normal part of the physician’s overall service to patients. In the poorest communities, it may not be possible to meet the needs of the indigent for physicians’ services by relying solely on local physicians. The local physicians should be able to turn for assistance to their colleagues in prosperous communities, particularly those in close proximity. Physicians are meeting their obligation, and are encouraged to continue to do so, in a number of ways such as: by seeing indigent patients in their offices at no cost or at reduced cost, by serving at freestanding or hospital clinics that treat the poor, and by participating in government programs that deliver health care to the poor. Physicians can also volunteer their services at weekend clinics for the poor and at shelters for battered women or the homeless. In addition to meeting their obligation to care for the indigent, physicians can devote their energy, knowledge and prestige to designing and lobbying at all levels for better programs to provide care for the poor. (2) State, local, and specialty medical societies should help physicians meet their obligations to provide care to the indigent. By working together through their professional organizations, physicians can provide more effective services and reach more patients. Many societies have developed innovative programs and clinics to coordinate care for the indigent by physicians. These efforts can serve as a model for other societies as they assist their members in responding to the needs of the poor.
Maintaining Mental Health Services by States H-345.975 - Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.

Subscriber Identification Cards H-185.944 - Our AMA: (1) urges any pertinent official or governmental agency to require health insurance plans to issue identification cards to its subscribers which prominently identify the full legal name of the insured; name of the policy holder; identification numbers needed for claim submission; and the primary insurance company name with its appropriate mailing address; and (2) will advocate for legislative and regulatory sanctions against insurance companies which present obstacles to the timely filing of claims which result in the denial of benefits.
Resolution 28
(A-18)

Introduced by: Region 6; Georgetown University School of Medicine Section

Subject: Improved Regulations on Electronic Nicotine Delivery Systems (ENDS) and Electronic Cigarettes

Referred to: MSS Reference Committee (Celeste Peay, Chair)

Whereas, Physicians are responsible for ensuring that therapeutic devices and drugs do more harm than good for their patients;¹ and

Whereas, Tobacco smoking is responsible for significant morbidity and mortality in the United States, and is the leading cause of preventable death;² and

Whereas, Smoking cessation devices such as nicotine patches have been proven to be safe and effective at reducing cigarette smoking;³,⁴ and

Whereas, Electronic nicotine delivery systems (ENDS) also called e-cigarettes, or vaporizers, have emerged as possible nicotine-replacement tools to replace traditional cigarette smoking. These devices have been promoted as safer than traditional cigarettes, however recent randomized controlled trials, systematic reviews, and meta-analyses have shown that electronic cigarette use is not associated with reduced cigarette smoking;⁵,⁶,⁷,⁸ and

Whereas, Recent studies have shown toxic levels of heavy metals can be released from ENDS. While they do show reduced levels of particulate exposure, promoting their use as smoking-cessation devices may be substituting one toxin for another;⁹,¹⁰,¹¹ and

Whereas: Use of ENDS and their use among adolescents has increased significantly in the past few years,¹²,¹³ and

Whereas: ENDS manufacturers are promoting use among adolescents with easy to conceal devices and online purchasing;¹³ and

Whereas: The portability and easily concealable nature of ENDS allow adolescents to imbibe nicotine in areas where public health efforts have made smoking prohibited, such as schools;¹³ and

Whereas: Studies have also shown that ENDS use in adolescents is associated with increased cigarette smoking later in life, essentially serving as a lead-in drug for harmful behaviors;¹⁴ and

Whereas, Physicians should not recommend a product that may be of uncertain safety when safer alternatives exist; and

Whereas, The FDA has recently delayed rules on the regulation of electronic cigarettes until August 2022, which would have significantly reduced their prevalence in the market;⁵,¹⁵ and

Whereas, Existing AMA policy urges physicians to “promote the use of FDA-approved cessation tools and resources to their patients” (H-495.972) and encourages the FDA “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” (H-495.973); and

Whereas, Existing AMA policy encourages the passage of laws that restrict electronic cigarette sales to children under 21 and laws that prevent targeted advertising of minors (H-495.986); and therefore be it

RESOLVED, That our AMA acknowledge the known harms of electronic nicotine delivery systems, particularly their ineffectiveness as smoking cessation devices, and encourage physicians to recommend alternative therapies for smoking-cessation; and be it further

RESOLVED, That our AMA work with federal agencies to discourage the promotion of electronic nicotine delivery systems both among adolescents and as smoking cessation devices; and be it further

RESOLVED, That our AMA amend Policy H-495.973 as follows:


FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973

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 ≥ 21; (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.

And be it further

Resolved, That our AMA amend policy H-495.986 as follows

Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986

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; and (10) opposes the
sale and development easily concealable electronic nicotine delivery systems
and e-cigarettes.

Fiscal Note: Significant, 12

Date Received: 04/11/2018

RELEVANT AMA AND AMA-MSS POLICY

Electronic Cigarettes, Vaping, and Health: 2014 Update H-495.972
1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery
systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these
products and the potential for nicotine addiction and the potential hazards of dual use with
conventional cigarettes, and be sensitive to the possibility that when patients ask about e-
cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical
interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-
approved smoking cessation tools and resources for their patients and caregivers; and (d)
advise patients who use e-cigarettes to take measures to assure the safety of children in the
home who could be exposed to risks of nicotine overdose via ingestion of replacement e-
cigarette liquid that is capped or stored improperly. 2. Our AMA encourages further clinical and
epidemiological research on e-cigarettes. 3. Our AMA supports education of the public on
electronic nicotine delivery systems (ENDS) including e-cigarettes.

FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and
Tobacco Products H-495.973
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.

Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986

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.

500.006MSS Restricting the Sale of E-Cigarettes to Minors:
AMA-MSS supports (1) increased clinical research on the effects of electronic cigarettes; and (2) education on the effects of e-cigarettes to parents and their children in various settings ranging from schools to clinics. (MSS Res 1, A-14)
Whereas, Transient loss of consciousness (TLoC) is defined by a temporary loss of consciousness with full recovery;¹ and

Whereas, TLoC can be attributed to multiple conditions including situational syncope, orthostatic hypotension, epilepsy, and psychogenic disorders;¹ and

Whereas, A neurological etiology is the most common cause of TLoC, and most commonly occurs in young adults;² and

Whereas, Motor vehicle accidents involving drivers with medical conditions other than epilepsy are 26 times more likely to occur than accidents involving drivers with epilepsy;³ and

Whereas, Each state mandates individualized driving restrictions in patients who experience an episode of TLoC that varies from three months to two years, and in some states physicians are required to report these patients to the Department of Motor Vehicles;⁴,⁵ and

Whereas, Physicians may be liable for motor vehicle crashes involving a patient if the physician fails to report the patient in a state that has mandatory reporting laws, or may be subject to punishment by the State Medical Board;⁶,⁷ and

Whereas, Overall safety with driving after TLoC due to epilepsy is dependent upon the patient’s physical status including motor and visual acuity, as well as compliance with state law and medical advice provided by the individual’s physician;¹ and

Whereas, Research shows that as many as 45% of ineligible drivers with epilepsy are still driving, even with full knowledge of their state’s law;⁵ and

Whereas, The American Academy of Neurology provides no set recommendations on the post-seizure driving guidelines, only stating that patients who defer treatment are more likely to lose driving privileges;¹⁰ and

Whereas, The American College of Cardiology, in collaboration with the American Society of Emergency Physicians and the Society for Academic Emergency Medicine, recommends no longer than a 3-month restriction period for an episode of TLoC in a patient who has been properly evaluated and treated;¹¹ and

Whereas, More permissive restrictions may not affect the cumulative crash risk for all individuals with epilepsy, but it may reduce the risk for individual patients by promoting better compliance with driving restrictions; evidenced in Arizona where the shortening of driving restrictions from 12 months to 3 months did not show any statistically significant difference in the number of seizure-induced motor vehicle accidents;¹²,¹³

Whereas, Most patients are fit to drive by 6 months post TLoC episode;¹⁴ and

Whereas, A patient’s functional ability to drive is unique to each patient’s presentation and risk of episode recurrence, and patients should be assessed by the collaborative effort of physicians and qualified driving performance examiners for proper cognitive, motor, and affective functions;¹⁴,¹⁵

Whereas, The AMA Code of Medical Ethics (8.2) states physicians should be involved in evaluating and reporting medically-impaired drivers for the safety of the patient and others; and

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Whereas, The AMA supports the formation of Medical Advisory Boards (H-15.995) to oversee the licensing of patients with conditions that could potentially impact their driving, and encourages physicians to have open conversations with patients about driving and their health conditions in accordance with state law (H-15.972); and

Whereas, In the most recent report published by the AMA Council on Science and Public Health, it was identified that despite the goal of these restrictions to ensure safety of the patient and other individuals, restrictions “may unduly harm the welfare of some individuals for whom driving is an economic, social, educational and/or recreational necessity;” therefore be it

RESOLVED, That our AMA-MSS support the evidenced-based standardization of state laws regulating driving restrictions for patients who experience an episode of transient loss of consciousness.

Fiscal Note: Minimal, 4

Date Received: 04/11/18

RELEVANT AMA AND AMA-MSS POLICY
Code of Medical Ethics Opinion 8.2
Impaired Drivers & Their Physicians
A variety of medical conditions can impair an individual’s ability to operate a motor vehicle safely, whether a personal car or boat or a commercial vehicle, such as a bus, train, plane, or commercial vessel. Those who operate a vehicle when impaired by a medical condition pose threats to both public safety and their own well-being. Physicians have unique opportunities to assess the impact of physical and mental conditions on patients’ ability to drive safely and have a responsibility to do so in light of their professional obligation to protect public health and safety. In deciding whether or how to intervene when a patient’s medical condition may impair driving, physicians must balance dual responsibilities to promote the welfare and confidentiality of the individual patient, and to protect public safety. Not all physicians are in a position to evaluate the extent or effect of a medical condition on a patient’s ability to drive, particularly physicians who treat patients only on a short-term basis. Nor do all physicians necessarily have appropriate training to identify and evaluate physical or mental conditions in relation to the ability to drive. In such situations, it may be advisable to refer a potentially at-risk patient for assessment.

To serve the interests of their patients and the public, within their areas of expertise physicians should:
(a) Assess at-risk patients individually for medical conditions that might adversely affect driving ability, using best professional judgment and keeping in mind that not all physical or mental impairments create an obligation to intervene.
(b) Tactfully but candidly discuss driving risks with the patient and, when appropriate, the family when a medical condition may adversely affect the patient’s ability to drive safely. Help the patient (and family) formulate a plan to reduce risks, including options for treatment or therapy if available, changes in driving behavior, or other adjustments.

(c) Recognize that safety standards for those who operate commercial transportation are subject to governmental medical standards and may differ from standards for private licenses.
(d) Be aware of applicable state requirements for reporting to the licensing authority those patients whose impairments may compromise their ability to operate a motor vehicle safely.
(e) Prior to reporting, explain to the patient (and family, as appropriate) that the physician may have an obligation to report a medically at-risk driver:
   When the physician identifies a medical condition clearly related to the ability to drive
   When continuing to drive poses a clear risk to public safety or the patient's own well-being and the patient ignores the physician's advice to discontinue driving
   When required by law
(f) Inform the patient that the determination of inability to drive safely will be made by other authorities, not the physician.
(g) Disclose only the minimum necessary information when reporting a medically at-risk driver, in keeping with ethics guidance on respect for patient privacy and confidentiality.

Medical Advisory Boards in Driver Licensing H-15.995
Our AMA (1) endorses the establishment of state motor vehicle department medical advisory boards to improve licensure of vehicle operators and to reduce incidence of injury and death and (2) urges state medical associations to encourage establishment of such boards and to work actively with them.

Licensing People to Drive H-15.972
It is the policy of the AMA (1) to encourage research into the many components and activities of the driving task and into the development of more accurate testing devices;
(2) that physicians continue to warn patients about the possibility of untoward side effects from medications, particularly those that might impair driving;
(3) that the physician attempt to give competent advice about the wisdom of the patient's driving, while keeping in mind the obligation to protect the community and obey the law; and
(4) that the physician, if uncertain about the patient's ability to drive, consider recommending that the state licensing agency arrange a driving test.

Elderly's Eligibility for Automobile Insurance and Licensure H-15.997
Although physicians are willing to examine applicants and determine whether or not the applicant meets specified physical standards for automobile liability insurance or for licenses to operate motor vehicles, the determination of what standards should be required or whether the driver is insurable and should be licensed to drive is the responsibility of the insurance companies concerned and of the state agencies issuing licenses.

Reevaluation of Elderly Drivers: The MSS formally establishes support for the following HOD policies:
H-15.972 Licensing People to Drive
It is the policy of the AMA (1) to encourage research into the many components and activities of the driving task and into the development of more accurate testing devices; (2) that physicians continue to warn patients about the possibility of untoward side effects from medications, particularly those that might impair driving; (3) that the physician attempt to give competent advice about the wisdom of the patient's driving, while keeping in mind the obligation to protect
the community and obey the law; and (4) that the physician, if uncertain about the patient's ability to drive, consider recommending that the state licensing agency arrange a driving test.

**H-15.954 Older Driver Safety**

(1) Our AMA recognizes that the safety of older drivers is a growing public health concern that is best addressed through multi-sector efforts to optimize vehicle design, the driving environment, and the individual's driving capabilities, and: (a) believes that because physicians play an essential role in helping patients slow their rate of functional decline, physicians should increase their awareness of the medical conditions, medications, and functional deficits that may impair an individual's driving performance, and counsel and manage their patients accordingly; (b) encourages physicians to familiarize themselves with driver assessment and rehabilitation options, refer their patients to such programs whenever appropriate, and defer recommendations on permanent driving cessation until establishing that a patient’s driving safety cannot be maintained through medical interventions or driver rehabilitation; (c) urges physicians to know and adhere to their state’s reporting statutes for medically at-risk drivers; and (d) encourages continued scientific investigation into strategies for the assessment and management of driving safety in the clinical setting. (2) Our AMA encourages physicians to use the Physician’s Guide to Assessing and Counseling Older Drivers as an educational tool to assist them in helping their patients.
Resolution 30
(A-18)

Introduced by: Region 3; Sammar Ghannam, University of Texas Health San Antonio, Long School of Medicine; Ghada Ghannam, The University of Texas School of Law; Sema Hajmurad, University of Texas Medical Branch School of Medicine

Subject: Increasing Data Collection Pertaining to the Utilization and Need of Palliative Care and End-Of-Life Care in Refugee Populations Living in the United States

Referred to: MSS Reference Committee
(Celeste Peay, Chair)

Whereas, Ongoing complex humanitarian crises that force migration and produce refugees are impacting public health in the United States and globally;1,2 and

Whereas, Refugees arrive in their host countries suffering from the physical and psychological effects of torture and trauma;1,2 and

Whereas, Many refugees present with communicable diseases, such as tuberculosis and hepatitis, non-communicable diseases, mental illnesses, cancer, and physical trauma;1,3 and

Whereas, These infectious diseases and chronic exposure to poor health conditions lead to lower life expectancies in refugees;1 and

Whereas, The World Health Organization (WHO) has urged health professionals to provide health care and protection to refugees;4 and

Whereas, However, palliative care in seriously ill refugee patients has been completely neglected;5 and

Whereas, Holistic palliative care is an integral component of relief strategies;5 and

Whereas, Access to palliation and the mitigation of avoidable physical and psychosocial suffering are affirmed as fundamental human rights by the international palliative care community;\(^5\) and

Whereas, Palliative care is an approach that improves the quality of life of patients and their families with life-threatening illnesses through the prevention and relief of suffering by means of early identification, correct assessment, treatment of pain, and other problems (physical, psychosocial, or spiritual problems);\(^6\) and

Whereas, Research and data collection regarding the need and utilization of palliative care and end-of-life care services in refugee populations living in the United States needs to be performed in order to better understand the current situation;\(^5\) and

Whereas, Increasing research about the end-of-life care that refugees receive in the United States is essential in order to write policy, train humanitarian healthcare teams to deliver palliative care, and to ensure that refugees receive end-of-life care tailored to them;\(^5\) and

Whereas, Existing palliative care competencies do not all translate easily into crisis settings;\(^5\) and

Whereas, Palliative care supports the idea that there is an inherent dignity of the individual;\(^7\) and

Whereas, Those who are in need of palliative care are not receiving it and that is of grave concern;\(^3\) and

Whereas, Palliative care, public health, and human rights all intersect and have a role in this complex issue of caring for the refugees;\(^7\) and be it further

RESOLVED, That our AMA-MSS support the effort of increasing research pertaining to the need for palliative care in refugee populations, the unique palliative care needs of refugees, and costs and effectiveness of potential palliative care interventions;

Fiscal Note: Minimal, 4

Date Received: 04/11/18

RELEVANT AMA AND AMA-MSS POLICY

**Increasing Access to Healthcare Insurance for Refugee Populations H-350.956**

Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees.

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5.1 Advance Care Planning - AMA Principles of Medical Ethics: I,IV
The process of advance care planning is widely recognized as a way to support patient self-determination, facilitate decision making, and promote better care at the end of life. Although often thought of primarily for terminally ill patients or those with chronic medical conditions, advance care planning is valuable for everyone, regardless of age or current health status. Planning in advance for decisions about care in the event of a life-threatening illness or injury gives individuals the opportunity to reflect on and express the values they want to have govern their care, to articulate the factors that are important to them for quality of life, and to make clear any preferences they have with respect to specific interventions. Importantly, these discussions also give individuals the opportunity to identify who they would want to make decisions for them should they not have decision-making capacity.

Proactively discussing with patients what they would or would not want if recovery from illness or injury is improbable also gives physicians opportunity to address patients’ concerns and expectations and clarify misunderstandings individuals may have about specific medical conditions or interventions. Encouraging patients to share their views with their families or other intimates and record them in advance directives, and to name a surrogate decision maker, helps to ensure that patients’ own values, goals, and preferences will inform care decisions even when they cannot speak for themselves.

Physicians must recognize, however that patients and families approach decision making in many different ways, informed by culture, faith traditions, and life experience, and should be sensitive to each patient’s individual situations and preferences when broaching discussion of planning for care at the end of life.

Physicians should routinely engage their patients in advance care planning in keeping with the following guidelines:

(a) Regularly encourage all patients, regardless of age or health status, to:
   (i) think about their values and perspectives on quality of life and articulate what goals they would have for care if they faced a life-threatening illness or injury, including any preferences they may have about specific medical interventions (such as pain management, medically administered nutrition and hydration, mechanical ventilation, use of antibiotics, dialysis, or cardiopulmonary resuscitation);
   (ii) identify someone they would want to have make decisions on their behalf if they did not have decision-making capacity;
   (iii) make their views known to their designated surrogate and to (other) family members or intimates.

(b) Be prepared to answer questions about advance care planning, to help patients formulate their views, and to help them articulate their preferences for care (including their wishes regarding time-limited trials of interventions and surrogate decision maker). Physicians should also be prepared to refer patients to additional resources for further information and guidance if appropriate.

(c) Explain how advance directives, as written articulations of patients’ preferences, are used as tools to help guide treatment decisions in collaboration with patients themselves when they have decision-making capacity, or with surrogates when they do not, and explain the surrogate’s responsibilities in decision making. Involve the patient’s surrogate in this conversation whenever possible.

(d) Incorporate notes from the advance care planning discussion into the medical record. Patient values, preferences for treatment, and designation of surrogate decision maker should be included in the notes to be used as guidance when the patient is unable to express his or her own decisions. If the patient has an advance directive document or written designation of proxy,
include a copy (or note the existence of the directive) in the medical record and encourage the patient to give a copy to his or her surrogate and others to help ensure it will be available when needed.

(e) Periodically review with the patient his or her goals, preferences, and chosen decision maker, which often change over time or with changes in health status. Update the patient’s medical records accordingly when preferences have changed to ensure that these continue to reflect the individual’s current wishes. If applicable, assist the patient with updating his or her advance directive or designation of proxy forms. Involve the patient’s surrogate in these reviews whenever possible.

**Educating Physicians About Advance Care Planning H-85.956**

Our AMA: (1) will continue efforts to better educate physicians in the skills necessary to increase the prevalence and quality of meaningful advance care planning, including the use of advance directives, and to improve recognition of and adherence to a patient's advance care decisions; (2) supports development of materials to educate physicians about the requirements and implications of the Patient Self-Determination Act, and supports the development of materials (including, but not necessarily limited to, fact sheets and/or brochures) which physicians can use to educate their patients about advance directives and requirements of the Patient Self-Determination Act; (3) encourages residency training programs, regardless of or in addition to current specialty specific ACGME requirements, to promote and develop a high level of knowledge of and ethical standards for the use of such documents as living wills, durable powers of attorney for health care, and ordering DNR status, which should include medical, legal, and ethical principles guiding such physician decisions. This knowledge should include aspects of medical case management in which decisions are made to limit the duration and intensity of treatment; (4) will work with medical schools, graduate medical education programs and other interested groups to increase the awareness and the creation of personal advance directives for all medical students and physicians; and (5) encourages development of a model educational module for the teaching of advance directives and advance care planning.

**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.

**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.

**Good Palliative Care H-70.915**

Our AMA: (1) encourages all physicians to become skilled in palliative medicine; (2) recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families; (3) encourages education programs for all appropriate health care professionals, and the public as well, in care of the dying patient; and the care of patients with disabling chronic or life-limiting illness; (4) supports improved reimbursement for health care practices that are important in good care of the dying patient, such as the coordination and continuity of care, "maintenance" level services, counseling for patient and family, use of multidisciplinary teams, and effective palliation of symptoms; (5) encourages physicians to become familiar with the use of current coding methods for reimbursement of hospice and palliative care services; (6) advocates for reimbursement of Evaluation and Management (E/M) codes reflecting prolonged time spent on patients' care outside of the face-to-face encounter in non-hospital settings; (7) continues to monitor the development and performance on the CMS 30-day mortality measures and enrollments in the Medicare hospice program and the VA hospice programs and continues to work to have CMS exclude palliative patients from mortality measures; (8) supports efforts to clarify coding guidance or development of codes to capture "comfort care," "end-of-life care," and "hospice care;" (9) encourages research in the field of palliative medicine to improve treatment of unpleasant symptoms that affect quality of life for patients; and (10) encourages research into the needs of dying patients and how the care system could better serve them.

**Palliative Care and End-of-Life Care H-295.875**

Our AMA:

1. Reaffirms the Council on Medical Education's support of palliative medicine as a medical subspecialty with certification recognized by the American Board of Medical Specialties, and also encourages the inclusion of palliative medicine in the core curriculum of undergraduate and graduate medical education.
2. Encourages the training of all allied health workers in the use of palliative care techniques and interdisciplinary team care.
3. Will continue its efforts in producing and distributing clinical CME programs on pain management and end-of-life care.
4. Our AMA will work with relevant national medical specialty organizations to petition the American Board of Medical Specialties and relevant specialty boards to support development of innovative fellowship models that would qualify physicians for board certification in the fields of hospice and palliative medicine as well as geriatrics.

**Hospice Coverage and Underutilization H-85.966**

The policy of the AMA is that: (1) The use of hospice care be actively utilized to provide the patient and family with appropriate physical and emotional support, but not preclude or prevent the use of appropriate palliative therapies to continue to treat the underlying malignant disease,
if the patient is showing response to such palliative therapy; (2) The goal of terminal care is to relieve patient suffering and not necessarily to cure incurable disease; (3) Appropriate active palliation should be a covered hospital benefit; and (4) The initiation of hospice care may be done at the discretion of the attending physician without stopping whatever medical care is being rendered if the physician believes the patient is in the last six months of life.

**Refugee Health Care 250.020MSS**

AMA-MSS will ask the AMA to (1) recognize the unique health needs of refugees; (2) encourage the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees. (MSS Amended Res 4, A-09) (AMA Res 804, I-09 [H-350.957]) (Modified and Reaffirmed: MSS GC Rep A, I-14).
AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 31 (A-18)

Introduced by: Tabitha Moses, Lara Fahmy, Aileen Haque; Wayne State University School of Medicine, Palavi Vaidya; University of Toledo College of Medicine, Krish Nair; Northeast Ohio Medical University

Subject: Support the Use of Heroin Assisted Treatment Programs

Referred to: MSS Reference Committee (Celeste Peay, Chair)

Whereas, More than 828,000 people older than 12 in the United States used heroin within the past year;¹ and

Whereas, the rate of deaths from drug overdose has increased 137% with a 200% increase in rate of overdose deaths involving opioids;² and

Whereas, A 2015 systematic review and meta-analysis of randomized control trials conducted in Switzerland, the Netherlands, Spain, Germany, Canada, and England, demonstrate benefits to supervised injectable heroin-assisted treatment (HAT) as a form of treatment for a subset of heroin-dependent patients who do not respond well to other treatment options;³ and

Whereas, The British Medical Association, the Swiss Society of Addiction Medicine, and the European Monitoring Centre for Drugs and Drug Addiction have previously spoken in support of the use of HAT for heroin addiction;⁴,⁵,⁶ and

Whereas, The American Society of Addiction Medicine (ASAM) supports the use of pharmacological therapies for opioid use disorder, although to the extend of our knowledge, it does not currently have a stance on HAT;⁷ and

Whereas, Pharmaceutical-grade heroin (diamorphine) is registered as a medical product for use as HAT in at least 5 countries: Switzerland, the Netherlands, Germany, United Kingdom, and Denmark;³ and

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Whereas, A recent meta analysis of six randomized control trials found that across all trials benefits of HAT included higher retention in treatment and lower mortality;

Whereas, Injectable HAT was found to be more effective than oral methadone with an increased addiction treatment retention rate;

Whereas, There is greater improvement in health-related quality of life (particularly in terms of physical health) for patients with severe heroin dependence under HAT compared to methadone;

Whereas, In the 2014 Randomized Injectable Opioid Treatment Trial supervised injectable HAT was found to make significant reductions in street heroin use after 6 months of treatment in addicts that were previously unresponsive to treatment; and

Whereas, The health of chronic intravenous drug users who underwent a HAT plan was improved with a reduction in viral hepatitis compared to users who did not undergo the same treatment plan; and

Whereas, Patients on HAT (compared to those on methadone treatment) saw significant improvement in regard to medical and psychiatric status, economic status, employment situation, and family and social relations; and

Whereas, Treatment with supervised injectable HAT was shown to decline patients’ involvement with self-disclosed illicit and criminal activities compared to other substitution therapies; and

Whereas, HAT may be more cost-effective due to lower estimated law enforcement costs compared to treatment with methadone alone for chronic, treatment-resistant heroin addicts; and

Whereas, Current AMA policy states that “methadone should not be designated as the sole preferred analgesic by any insurance payer, whether public or private” reflecting a precedent for the AMA to make recommendations regarding specific treatments (H-120.937); and

Whereas, Current AMA policy is to “support basic and clinical research...to enhance treatment efficacy” and “endorse the concept of prompt access to treatment for chemically dependent patients, regardless of the type of addiction” (H-95.956); therefore be it

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RESOLVED, That our AMA support the use of heroin-assisted treatment (HAT) programs for heroin-dependent patients; and be it further

RESOLVED, That our AMA remove policy H-55.991, Use of Heroin in Terminally Ill Cancer Patients With Severe Chronic Pain

Fiscal Note: Minimal, 6

Date Received: 4/11/2018

RELEVANT AMA POLICY:

Use of Heroin in Terminally Ill Cancer Patients With Severe Chronic Pain H-55.991
Our AMA remains opposed to legislation or any other action that would reschedule heroin from Schedule 1 to Schedule 2 of the Controlled Substances Act.

Treatment of Opioid Dependence D-120.953
Our AMA will work to end the limitation of 100 patients per certified physician treating opioid dependence after the second year of treatment as currently mandated by the Drug Addiction Treatment Act.

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.

Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985
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. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management.

Opioid Treatment and Prescription Drug Monitoring Programs D-95.980
Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.

Curtailing Prescription Drug Abuse While Preserving Therapeutic Use - Recommendations for Drug Control Policy H-95.979
Our AMA (1) opposes expansion of multiple-copy prescription programs to additional states or classes of drugs because of their documented ineffectiveness in reducing prescription drug abuse, and their adverse effect on the availability of prescription medications for therapeutic use; (2) supports continued efforts to address the problems of prescription drug diversion and abuse through physician education, research activities, and efforts to assist state medical societies in developing proactive programs; and (3) encourages further research into
development of reliable outcome indicators for assessing the effectiveness of measures proposed to reduce prescription drug abuse.

**Methadone Should Not Be Designated as the Sole Preferred Analgesic H-120.937**
Our AMA recommends that methadone should not be designated as the sole preferred analgesic by any insurance payer, whether public or private.

**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.

**RELEVANT AMA-MSS POLICY:**

**Promoting Prevention of Fatal Opioid Overdose (MSS100.010)**
AMA-MSS will ask the AMA to (1) encourage the establishment of new pilot programs directed towards heroin overdose treatment with naloxone; and (2) advocate for encourage the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities. (MSS Res 36, I-11)

**Naloxone Administration and Heroin Overdose (MSS100.007)**
AMA-MSS will ask the AMA to: (1) recognize the great burden that both prescription and non-prescription opiate addiction and abuse places on patients and society alike and reaffirm its support for the compassionate treatment of patients with opiate addiction; (2) monitor the progress of nasal naloxone studies and report back as needed; and (3) work to remove obstacles to physicians who wish to conduct ethical and needed research in the area of addiction medicine. (MSS Rep A, A-05) (AMA Amended Res 526, A-06 Adopted [D- 95.987]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)
Whereas, Motor vehicle crashes are the leading causes of death for teenagers in the United States (16-19);¹ and

Whereas, 16-19-year-old drivers are involved in fatal accidents at triple the rate of drivers over the age of 20, as the risk of fatal accidents per mile driven is highest among 16-17-year-old drivers and twice the rate of 18-19-year-old drivers;² and

Whereas, Teenagers ages 16 to 19 involved in fatal motor vehicle crashes are twice as likely to bear significant responsibility for their crash compared to similar fatal crashes of older counterparts;³ and

Whereas, Teenage crash risk is highest in the first year of independent driving, and increases almost 3-7 times for the first 6 months of unsupervised driving compared to supervised driving;⁴,⁵ and

Whereas, Newly licensed teenage drivers are twice as likely to crash in their first month of driving than they are after a year of experience, and most incidents are due to difficulty recognizing and responding to hazards or errors in judgement due to lack of experience;⁶,⁷,⁸ and

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⁷ McDonald CC, Curry AE, Kandadai V, et. al. Comparison of teen and adult driver crash scenarios in a nationally representative sample of serious crashes. Accident Analysis & Prevention 2014;72:302-308.
Whereas, Although inexperience seems to play a role, driver age is an important factor as novice teenage driver crash rates are elevated compared to older novice driver crash rates;\(^9\) and

Whereas, The risk of fatal crashes amongst teenage drivers increases with the number of teenage passengers;\(^10,11,12\) and

Whereas, Graduated Driver Licensing programs were first implemented in the 1990s to delay full licensure while allowing beginners to obtain experience under low risk conditions and consist of three stages: an extended learner phase under adult supervision, an intermediate license with restrictions, and finally an unrestricted driver’s license after completion of the first two stages;\(^13\) and

Whereas, Graduated Driver Licensing (GDL) programs have been associated with a 20-40\% reduction in overall crash risk and an 8-25\% reduction in fatal crash rates among teenage drivers;\(^14,15,16,17,18,19,20\) and

Whereas, All 50 states and the District of Columbia have adopted some form of GDL system, but each state implements programs with varying provisions, such as South Carolina granting a full privilege license as young as 16\(\frac{1}{2}\) years old and neighboring Georgia at 18 years old;\(^21\) and

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Whereas, The NIH and United States Department of Transportation have found that the most effective legislation includes at least 5 of the following seven elements, “A minimum age of 16 for a learner’s permit, a mandatory waiting period of at least six months before a driver can apply for an intermediate license, a requirement for 50 to 100 hours of supervised driving before testing for an intermediate license, a minimum age of 17 for an intermediate license, restrictions on nighttime driving, a limit on the number of teenaged passengers allowed in the car, and a minimum age of 18 for a full license.”

Whereas, As of March 2018 no states have adopted all of the best practices for state GDL laws proposed by the Insurance Institute for Highway Safety; and

Whereas, The most influential components of varying GDL programs in lowering the risk of fatal teen crashes are a delayed permit and licensing age, more required practice hours, nighttime restrictions, and teenage passenger restrictions; therefore be it

RESOLVED, That our AMA support the standardization and implementation of more comprehensive Graduated Driver Licensing programs including but not limited to increasing permit and licensing age requirements, mandatory minimum training hours, and nighttime and teenage passenger restrictions.

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Relevant AMA and AMA-MSS Policy:

AMA Licensing People to Drive H-15.972
It is the policy of the AMA (1) to encourage research into the many components and activities of the driving task and into the development of more accurate testing devices; (2) that physicians continue to warn patients about the possibility of untoward side effects from medications, particularly those that might impair driving; (3) that the physician attempt to give competent advice about the wisdom of the patient's driving, while keeping in mind the obligation to protect the community and obey the law; and (4) that the physician, if uncertain about the patient's ability to drive, consider recommending that the state licensing agency arrange a driving test.

Older Driver Safety H-15.954
(1) Our AMA recognizes that the safety of older drivers is a growing public health concern that is best addressed through multi-sector efforts to optimize vehicle design, the driving environment, and the individual's driving capabilities, and:
   (a) believes that because physicians play an essential role in helping patients slow their rate of functional decline, physicians should increase their awareness of the medical conditions, medications, and functional deficits that may impair an individual's driving performance, and counsel and manage their patients accordingly;
   (b) encourages physicians to familiarize themselves with driver assessment and rehabilitation options, refer their patients to such programs whenever appropriate, and defer recommendations on permanent driving cessation until establishing that a patient's driving safety cannot be maintained through medical interventions or driver rehabilitation;
   (c) urges physicians to know and adhere to their state's reporting statutes for medically at-risk drivers;
   and
   (d) encourages continued scientific investigation into strategies for the assessment and management of driving safety in the clinical setting.

(2) Our AMA encourages physicians to use the Physician's Guide to Assessing and Counseling Older Drivers as an educational tool to assist them in helping their patients.

Medical Advisory Boards in Driver Licensing H-15.995
Our AMA (1) endorses the establishment of state motor vehicle department medical advisory boards to improve licensure of vehicle operators and to reduce incidence of injury and death and (2) urges state medical associations to encourage establishment of such boards and to work actively with them.
Automobile-Related Injuries H-15.990

Our AMA:

1. Encourages physicians to increase their awareness of the still largely overlooked problem of motor vehicle-related injuries and to discuss with their patients how they can avoid or prevent such injuries.

2. Calls for the establishment of a reduction in motor vehicle injuries as a national goal.

3. Reaffirms its support for the development of effective passive crash protection systems for occupants of motor vehicles.

4. Strongly endorses and encourages the use of active restraints, such as lapbelts, lapbelt-shoulder harnesses, and those that are approved for children.

5. Encourages motor vehicle manufacturers to develop automobiles with stronger passenger compartments that would more effectively protect occupants, and with interiors having fewer protuberant objects and hard surfaces that could cause injuries in crashes.

6. Continues to support state and federal legislative efforts to strengthen drunk driving laws and their enforcement.

7. Encourages national and federal organizations, such as the National Institutes of Health, the National Highway Transportation Safety Agency, and the National Science Foundation, and appropriate private groups, to devote more of their resources to research concerning vehicle-related injuries and their prevention.

8. Urges states to review their standards for the construction and maintenance of roads and highways. The standards should be based on current engineering knowledge and good practice, particularly as related to use of skid-resistant surfaces; shoulder grading; drivers' lines of vision; removal of obstructions; and separation of opposing traffic streams.

9. Encourages state and local officials to monitor streets, roads, and highways to identify sites with disproportionate risks of crashes, in order to take appropriate remedial actions.

10. Encourages continued study of the effect of increasing the legal age at which young persons may drink alcoholic beverages and supports increased study of behavioral factors in crashes, such as those relating to education, training and driving experience; school, family and work problems; aggression; depression and personality disorders; use of drugs; and criminal behavior.

11. Believes that, before the adoption of passive crash protection systems and devices to reduce motor vehicle injuries, industry and government demonstrate through field studies that such systems and devices are effective, safe, cost-effective and acceptable to drivers.

12. Supports the use of legal and constitutional sobriety checkpoints to deter driving following alcohol consumption.

13. Will work with interested state medical societies to pursue legislation to overturn bans on the use of sobriety checkpoints.

Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958

Our AMA: (1) defines sleepiness behind the wheel as a major public health issue and encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups;

(2) recommends that the National Institutes of Health and other appropriate organizations
support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions. (3) recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep. (4) encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness-testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment. (5) urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology. (6) recommends that physicians: (a) become knowledgeable about the diagnosis and management of sleep-related disorders; (b) investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories; (c) inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries; (d) advise patients about possible medication-related effects that may impair their ability to safely operate a motor vehicle or other machinery; (e) inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries; and (f) become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice. (7) encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state. (8) recommends that guidelines be developed for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries. (9) reiterates its support for physicians’ use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.

**Options for Improving Motorcycle Safety D-15.999**

Our AMA: (1) encourages the National Highway Traffic Safety Administration to work with medical and public health organizations, national motorcycle rider organizations, state motor vehicle licensing agencies, law enforcement officials, and the motorcycle industry to develop a comprehensive national motorcycle safety plan that addresses rider education, training, and licensing; use of motorcycle helmets and other protective gear; public awareness of motorcycles; alcohol use among motorcyclists and other motor vehicle drivers; measures to
increase the visibility of motorcyclists and motorcycles to other drivers; engineering and design of motorcycles and highway environments; and research to determine the effectiveness of current and proposed safety measures; and

(2) encourages physicians to (a) be aware of motorcycle risks and safety measures and (b) counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs.

**Automatic (i.e., Passive) Restraints to Prevent Injuries and Deaths from Motor Vehicle Accidents**  
H-15.986

The AMA (1) supports legislation to promote availability of effective seat belts in school buses in the U.S.; and (2) supports legislative action to promote availability of effective seat belts in all motor vehicles in public use (e.g., public and private buses, taxicabs, and any other vehicles carrying passengers).

**Motor Vehicle Accidents**  
H-15.992

Our AMA (1) recognizes motor vehicle-related trauma as a major public health problem, the resolution of which requires a leadership role by physicians in concert with safety experts; and (2) strongly encourages other medical and health care organizations, as well as departments of health and transportation, to endorse the concept of motor vehicle related trauma as a public health problem, thereby lending its treatment to traditional public health measures.

**AMA-MSS**

370.012 **Organ Donation Education Programs in Driver Training Programs**

AMA-MSS will ask the AMA to encourage all states to include organ and tissue donation education in pre-licensing and drivers training programs.

15.001 **State Motorcycle Helmet Laws**

Our AMA-MSS will ask the AMA to: (1) endorse the concept of legislative measures to require the use of helmets when riding or driving a motorcycle; (2) urge constituent societies to support the enactment or preservation of state motorcycle helmet laws; and (3) join, when requested, with constituent societies to support the enactment or preservation of state motorcycle helmet laws.

15.003 **Mandatory Seat Belt Utilization Laws**

AMA-MSS will ask the AMA to support mandatory seat belt utilization laws, which do not simultaneously relieve automobile manufacturers of their responsibility to install passive restraints. (AMA Sub Res 133, A-85, 15.004 **Hazardsof All Terrain Vehicles**: AMA-MSS will ask the AMA to support increased safety standards for the operation of all terrain vehicles.

15.008 **Advocacy of a Highway-Rail Crossing Safety Program**
AMA-MSS supports programs set forth by the United States Department of Transportation – Federal Railroad Administration to ensure the safety at highway – rail crossings.

15.009MSS Seatbelt Use in Young Drivers and Passengers
AMA-MSS will ask the AMA to urge physicians to take an active stance with their young patients on the importance of safety in motor vehicles through routine questioning regarding passenger seat belt use during every history and physical exam.

15.010MSS Seat Belt Compliance in Emergency Vehicle Patient Compartments
AMA-MSS will ask the AMA to collaborate with national emergency medicine and emergency medical services organizations to develop educational resources and training for employees regarding seat belt usage in the patient compartments of emergency vehicles; and (2) support the amendment of state seat belt laws with blanket exemptions for emergency medical services personnel such that these laws provide exemptions only when actively involved in patient care.
AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution 33
(A-18)

Introduced by: Region 1; Region 5, Region 3; Allan Joseph Medwick, Western Michigan University Homer Stryker M.D. School of Medicine; Katherine Joyce, Geetika Srivastava, Andrew Ford, Hari Iyer, Manasa Melachuri, Vinchelle Hardison, Northeast Ohio Medical University; Nara Tashjian, Creighton University School of Medicine; Megan Winkelman, University of California, San Francisco School of Medicine; Stacy Jones, Harvard Medical School; Amar Patel, Texas Tech University Health Sciences Center School of Medicine; Angie Wan, Case Western Reserve University School of Medicine; Tabitha Moses, Wayne State University School of Medicine; Paige Anderson, University of Toledo College of Medicine and Life Sciences

Subject: Improving Support and Access for Medical Students with Disabilities

Referred to: MSS Reference Committee
(Celeste Peay, Chair)

Whereas, The Americans with Disabilities Act Amendments Act of 2008 defines a disability as “a physical or mental impairment that substantially limits one or more major life activities of an individual; a record of such an impairment; or being regarded as having such an impairment;”¹ and

Whereas, In enacting the Americans with Disabilities Act, “Congress recognized that physical and mental disabilities in no way diminish a person’s right to fully participate in all aspects of society, but that people with physical or mental disabilities are frequently precluded from doing so because of prejudice, antiquated attitudes, or the failure to remove societal and institutional barriers;”¹ and

Whereas, People with disabilities comprise 22.2 percent of the US adult population,² but only 2.7 percent of medical students³ and 2 to 10 percent of practicing physicians;⁴ and

Whereas, A disability can negatively impact individuals at all stages of a medical career and result in the need for reasonable accommodations as provided by law;⁵ and

Whereas, Accrediting bodies including but not limited to the Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA) have not established a uniform list of essential abilities and technical standards or requirements for reasonable accommodations in medical school or residency, which directly impacts a medical school’s willingness to provide accommodations as well as its understanding of accommodations, assistive technology, acceptable use of intermediaries, alternative learning experiences, and individualized assessment of disability under current law; and

Whereas, A recent study showed that most medical school technical standards do not support the provision of reasonable accommodations for students with disabilities as intended by the ADA (e.g., proscribing intermediaries and auxiliary aids for hearing, vision, and mobility disabilities); and

Whereas, Many medical school applicants and students may not be aware that they qualify for protection based on the broader definition of disability in the Americans with Disabilities Act Amendments Act of 2008 or may be discouraged from disclosing an existing or new disability arising from accident or disease due to fear of discrimination in admissions or licensure; and

Whereas, Existing AMA and AMA-MSS policies support improving access and support for clinicians, learners, and patients with disabilities (e.g., H-350.978, H-200.951, H-90.987, H-90.971, D-295.963); and

Whereas, Our AMA plays an existing role in developing policy and initiatives related to improving undergraduate medical education, including but not limited to the Accelerating Change in Medical Education Initiative, which has already begun to investigate meeting disability-related needs; and

Whereas, Improving support and access for medical students and physicians with disabilities can improve patient care, impact research agendas and workplace attitudes toward disability,

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13 American Medical Association. Academic Physicians Section. Available at: https://www.ama-assn.org/about/academic-physicians-section-ape
and reduce the significant barriers to health care, discrimination, and ableism experienced by people with disabilities;\textsuperscript{14,15,16,17,18,19,20} therefore be it

RESOLVED, That our AMA supports amending Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA) accreditation requirements to require all medical schools update their technical standards for the admission, retention, and graduation of medical students to reflect the requirements of the Americans with Disabilities Act Amendments Act of 2008 and other Federal disability non-discrimination laws, and publish them on public websites; and be it further

RESOLVED, That our AMA supports the adoption of technical standards that are limited to only the truly essential abilities required of a medical school graduate and clearly state that technical standards may be met with or without accommodations including assistive technology as recommended in Accessibility, Inclusion, and Action in Medical Education: Lived Experiences of Learners and Physicians With Disabilities, published by the American Association of Medical Colleges; and be it further

RESOLVED, That our AMA supports the individualized assessment of disability, as required by current law, and discourages blanket prohibitions of assistive technology such as the use of American Sign Language (ASL) interpreters, Communication Access Realtime Translation (CART, sometimes referred to as real-time captioning) services, FM systems (devices that use FM frequencies to amplify sound), and trained intermediaries for students, residents, and clinicians with physical disabilities; and be it further

RESOLVED, That our AMA supports the development of training and guidance for medical school faculty and administrators on communicating with and about persons with disabilities; writing appropriate technical standards for applicants, medical students, and residents; and identifying which technical standards are truly essential for all medical school graduates and residents by groups such as the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM).


Fiscal Note: Significant, 12

Date Received: 04/11/2018

RELEVANT AMA AND AMA-MSS POLICY

Relevant AMA Policy:

Discrimination B-14

Membership in the AMA or in any constituent association, national medical specialty society or professional interest medical association represented in the House of Delegates, shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities.

Civil Rights & Medical Professionals 9.5.4

Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.

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.

**Strategies for Enhancing Diversity in the Physician Workforce H-200.951**

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.

**Strategies for Enhancing Diversity in the Physician Workforce D-200.985**

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.

6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.

11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

**Equal Access for Physically Challenged Physicians H-90.987**

Our AMA supports equal access to all hospital facilities for physically challenged physicians as part of the Americans with Disabilities Act.

**Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992**

1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.
2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.

3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.

**Diversity in the Physician Workforce and Access to Care D-200.982**

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

**Creating an Effective Environment for Medical Student Education H-295.900**

1. The AMA encourages the development of a model student orientation program that includes workshops that address health awareness for students and standards of behavior for teachers and learners.

2. Our AMA will: (A) ask the Liaison Committee on Medical Education to ensure that medical schools have policies to protect medical students from retaliation based on reporting incidents of mistreatment; and (B) through the Learning Environment Study, conduct research and disseminate findings on the medical education learning environment including the positive and negative elements of that environment that impact the teacher-learner relationship; and (C) encourage the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to identify best practices and strategies to assure an appropriate learning environment for medical students.

**Medical Student Health and Well-Being H-295.927**

The AMA encourages the Association of American Medical Colleges, Liaison Committee on Medical Education, medical schools, and teaching hospitals to address issues related to the health and well-being of medical students, with particular attention to issues such as HIV infection that may have long-term implications for health, disability and medical practice, and consider the feasibility of financial assistance for students with disabilities.
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.

Teacher-Learner Relationship In Medical Education H-295.955

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics
must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people’s opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.

**Insurance Coverage for Medical Students and Resident Physicians H-295.942**

The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount
sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance.

**Due Process H-295.998**

(1) Our AMA reaffirms its 1974 approval of the policy adopted by the Liaison Committee on Medical Education, which states: “A medical school should develop and publicize to its faculty and students a clear definition of its procedures for the evaluation, advancement, and graduation of students. Principles of fairness and ‘due process’ must apply when considering actions of the faculty or administration which will adversely affect the student to deprive him of his valuable rights.”

(2) In addition, to clarify and protect the rights of medical students, the AMA recommends that: (a) Each school develop and publish in its catalog, student handbook or similar publication the institutional policies and procedures both for evaluation of academic performance (promotion, graduation, dismissal, probation, remedial work, and the like) and for nonacademic disciplinary decisions. (b) These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and written notification to the student that his/her academic/nonacademic performance is in question, and provide an opportunity for the student to learn why it has been questioned. (c) These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, he/she has adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce his/her own data. (d) The student should be allowed to be accompanied by a student or faculty advisor. (e) The policies and procedures should include an appeal mechanism within the medical school. (f) The student should be allowed to continue in the academic program during the proceedings unless extraordinary circumstances exist, such as physical threat to others.

**Discriminatory Questions on Applications for Medical Licensure D-295.319**

Our American Medical Association will work with the Federation of State Medical Boards and other appropriate stakeholders to develop model language for medical licensure applications which is non discriminatory and which does not create barriers to appropriate diagnosis and
treatment of psychiatric disorders, consistent with the responsibility of state medical boards to protect the public health.

Self-Incriminating Questions on Applications for Licensure and Specialty Boards H-275.945

The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked.

Continued Support for Diversity in Medical Education D-295.963

1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.

2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.

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.
Enhancing Accommodations for People with Disabilities H-90.971

Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

Remediation Programs for Physicians D-295.325

1. Our AMA supports the efforts of the Federation of State Medical Boards (FSMB) to maintain an accessible national repository on remediation programs that provides information to interested stakeholders and allows the medical profession to study the issue on a national level.

2. Our AMA will collaborate with other appropriate organizations, such as the FSMB and the Association of American Medical Colleges, to study and develop effective methods and tools to assess the effectiveness of physician remediation programs, especially the relationship between program outcomes and the quality of patient care.

3. Our AMA supports efforts to remove barriers to assessment programs including cost and accessibility to physicians.

4. Our AMA will partner with the FSMB and state medical licensing boards, hospitals, professional societies and other stakeholders in efforts to support the development of consistent standards and programs for remediating deficits in physician knowledge and skills.

5. Our AMA will ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to develop standards that would encourage medical education programs to engage in early identification and remediation of conditions, such as learning disabilities, that could lead to later knowledge and skill deficits in practicing physicians.

Medical Staff Development Plans H-225.961

1. All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The
professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, gender identity or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients and other aspects of the physician’s practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals.

2. The AMA communicates the medical staff development plan principles to the President and Chair of the Board of the American Hospital Association and recommend that state and local medical associations establish a dialogue regarding medical staff development plans with their state hospital association.

Relevant AMA-MSS Policy:

Availability of Medical Education 295.005MSS

AMA-MSS supports the following principles: (1) A determined, conscientious effort to accept, matriculate, and graduate minority physicians must be undertaken. (2) Support for programs with a commitment to the training of minority medical professionals, particularly the three predominantly black medical schools (Howard, Meharry, Morehouse) must be increased as necessary and maintained. (3) Adequate financial aid packages for minority students must be provided. These may include combinations of grants, loans, scholarships, or service-obligated programs. (4) Efforts should be made to increase the proportion of minorities in medical school faculties and administrative positions. (5) Efforts must be made to improve retention rates of minority students in medical schools.

Funding for Affirmative Action Programs 350.004MSS

AMA-MSS will ask the AMA to: (1) support counseling and intervention designed to increase minority enrollment, retention, and graduation of medical students; and (2) support increased funding appropriations to DHHS Health Careers Opportunities Program.

Minority Representation in the Medical Profession 350.003MSS

AMA-MSS will ask the AMA to: (1) support Affirmative Action in recruitment, retention, and graduation of minorities by all medical schools; and (2) urge private sources and federal and state governments to ensure sufficient funding to support increases in minority and economically disadvantaged student representation in medical schools.
The Disadvantaged Minority Health Improvement Act of 1989 350.011MSS

AMA-MSS publicly states and reaffirms and will ask the AMA to publicly state and reaffirm its stance on diversity in medical education and its strong opposition to the reduction of opportunities used to increase the number of minority and premedical students in training.

Dissemination of Disability Insurance Information 295.074MSS

AMA-MSS encourages medical schools to widely disseminate information to medical students regarding disability insurance and available policy options.

Expansion of Student Health Services 295.137MSS

AMA-MSS will ask the AMA to: (1) strongly encourage all medical schools to establish student health centers in order to provide adequate and timely medical and mental health care to their students; and (2) encourage medical schools to increase their student health center’s hours to include weekend coverage.

Adequate Insurance for Medical Students and Residents 295.027MSS

AMA-MSS will ask the AMA to: (1) urge all medical schools to pay for or offer affordable, policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) urge all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) urge medical schools and residency training programs to pay for or offer affordable health insurance to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) urge carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting.

Medical Student Access to Comprehensive Mental Health and Substance Abuse Treatment 295.164MSS

AMA-MSS strongly encourages the Association of American Medical Colleges and the Liaison Committee on Medical Education to conduct research into the number of US medical students with mental health and/or substance abuse concerns who either: 1. do not seek treatment due to the cost involved, or 2. have sought treatment, but do not feel that it has been adequate due to yearly visit and dollar limits placed on their care by their insurance plan.
Societal Discrepancies in the Disabled Population and Post-Secondary Disability Resource Center Utilization 90.007MSS

AMA-MSS (1) supports educating medical students and health care professionals on the societal discrepancies endured by the disabled population as well as services provided by post-secondary disability resource centers; and (2) will promote utilization of disability resource centers at the post-secondary level for students who meet the requirements established by those centers.

Student Workhour Reform 295.063MSS

AMA-MSS will ask the AMA to work diligently toward medical education reform that will train its future physicians in a more effective and humanistic environment.

Support Groups 295.001MSS

AMA-MSS will ask the AMA to encourage the development of alternative methods for dealing with the problems of student-physician mental health in medical schools and that these alternatives be available to students at the earliest possible point in their medical education.

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.

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.

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.
Policy Regarding HIV Infected Medical Students 20.012MSS

AMA-MSS will ask the AMA to take the stand that a medical student who becomes infected with human immunodeficiency virus (HIV) and other blood-borne infectious diseases should not be prevented from completing his or her course of study and receiving their MD/DO degree based solely on their HIV seropositivity.

Public Image of Physicians 445.001MSS

AMA-MSS: (a) will help develop community service and public education programs that serve to inform the public of health care issues and improve the public image of the AMA and the medical profession; and (b) will investigate possible advantages of involving medical students in AMA efforts to improve the public image of physicians and to assure the public that the primary role of physicians today continues to be that of advocates for their patient's health.

Cultural Competency Training For Medical School Faculty, Staff, and Students Concerning Individuals Who Are Lesbian, Gay, Bisexual, Transgender, Gender Nonconforming, and/or Born with Differences of Sexual Development 295.190MSS

Our AMA-MSS (1) supports the development and implementation of cultural competency programs by medical schools that train and guide medical school faculty, staff, and students in effective and compassionate communication with individuals of different backgrounds, including but not limited to gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age; and (2) support the development and implementation of supportive programs and confidential counseling services by medical schools to individuals within their institutions who have faced challenges due to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age.
AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution 33

(A-18)

Introduced by: Region 1; Region 5, Region 3; Allan Joseph Medwick, Western Michigan University Homer Stryker M.D. School of Medicine; Katherine Joyce, Geetika Srivastava, Andrew Ford, Hari Iyer, Manasa Melachuri, Vinchelle Hardison, Northeast Ohio Medical University; Nara Tashjian, Creighton University School of Medicine; Megan Winkelman, University of California, San Francisco School of Medicine; Stacy Jones, Harvard Medical School; Amar Patel, Texas Tech University Health Sciences Center School of Medicine; Angie Wan, Case Western Reserve University School of Medicine; Tabitha Moses, Wayne State University School of Medicine; Paige Anderson, University of Toledo College of Medicine and Life Sciences

Subject: Improving Support and Access for Medical Students with Disabilities

Referred to: MSS Reference Committee
(Celeste Peay, Chair)

Whereas, The Americans with Disabilities Act Amendments Act of 2008 defines a disability as “a physical or mental impairment that substantially limits one or more major life activities of an individual; a record of such an impairment; or being regarded as having such an impairment;”¹ and

Whereas, In enacting the Americans with Disabilities Act, “Congress recognized that physical and mental disabilities in no way diminish a person’s right to fully participate in all aspects of society, but that people with physical or mental disabilities are frequently precluded from doing so because of prejudice, antiquated attitudes, or the failure to remove societal and institutional barriers;”¹

Whereas, People with disabilities comprise 22.2 percent of the US adult population,² but only 2.7 percent of medical students³ and 2 to 10 percent of practicing physicians;⁴ and

Whereas, A disability can negatively impact individuals at all stages of a medical career and result in the need for reasonable accommodations as provided by law;⁵ and

Whereas, Accrediting bodies including but not limited to the Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA) have not established a uniform list of essential abilities and technical standards or requirements for reasonable accommodations in medical school or residency, which directly impacts a medical school’s willingness to provide accommodations as well as its understanding of accommodations, assistive technology, acceptable use of intermediaries, alternative learning experiences, and individualized assessment of disability under current law;⁶,⁷,⁸ and

Whereas, A recent study showed that most medical school technical standards do not support the provision of reasonable accommodations for students with disabilities as intended by the ADA (e.g., proscribing intermediaries and auxiliary aids for hearing, vision, and mobility disabilities);⁹ and

Whereas, Many medical school applicants and students may not be aware that they qualify for protection based on the broader definition of disability in the Americans with Disabilities Act Amendments Act of 2008 or may be discouraged from disclosing an existing or new disability arising from accident or disease due to fear of discrimination in admissions or licensure;¹⁰,¹¹,¹² and

Whereas, Existing AMA and AMA-MSS policies support improving access and support for clinicians, learners, and patients with disabilities (e.g., H-350.978, H-200.951, H-90.987, H-90.971, D-295.963); and

Whereas, Our AMA plays an existing role in developing policy and initiatives related to improving undergraduate medical education, including but not limited to the Accelerating Change in Medical Education Initiative, which has already begun to investigate meeting disability-related needs;¹³ and

Whereas, Improving support and access for medical students and physicians with disabilities can improve patient care, impact research agendas and workplace attitudes toward disability, and reduce the significant barriers to health care, discrimination, and ableism experienced by people with disabilities;¹⁴,¹⁵,¹⁶,¹⁷,¹⁸,¹⁹,²⁰ therefore be it

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RESOLVED, That our AMA supports amending Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA) accreditation requirements to require all medical schools update their technical standards for the admission, retention, and graduation of medical students to reflect the requirements of the Americans with Disabilities Act Amendments Act of 2008 and other Federal disability non-discrimination laws, and publish them on public websites; and be it further

RESOLVED, That our AMA supports the adoption of technical standards that are limited to only the truly essential abilities required of a medical school graduate and clearly state that technical standards may be met with or without accommodations including assistive technology as recommended in Accessibility, Inclusion, and Action in Medical Education: Lived Experiences of Learners and Physicians With Disabilities, published by the American Association of Medical Colleges; and be it further

RESOLVED, That our AMA supports the individualized assessment of disability, as required by current law, and discourages blanket prohibitions of assistive technology such as the use of American Sign Language (ASL) interpreters, Communication Access Realtime Translation (CART, sometimes referred to as real-time captioning) services, FM systems (devices that use FM frequencies to amplify sound), and trained intermediaries for students, residents, and clinicians with physical disabilities; and be it further

RESOLVED, That our AMA supports the development of training and guidance for medical school faculty and administrators on communicating with and about persons with disabilities; writing appropriate technical standards for applicants, medical students, and residents; and identifying which technical standards are truly essential for all medical school graduates and residents by groups such as the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM).

RELEVANT AMA AND AMA-MSS POLICY

Relevant AMA Policy:

Discrimination B-14

Membership in the AMA or in any constituent association, national medical specialty society or professional interest medical association represented in the House of Delegates, shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities.

Civil Rights & Medical Professionals 9.5.4

Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.

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.

**Strategies for Enhancing Diversity in the Physician Workforce H-200.951**

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.

**Strategies for Enhancing Diversity in the Physician Workforce D-200.985**

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.

6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.

11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

**Equal Access for Physically Challenged Physicians H-90.987**

Our AMA supports equal access to all hospital facilities for physically challenged physicians as part of the Americans with Disabilities Act.

**Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992**

1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.
2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.

3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.

Diversity in the Physician Workforce and Access to Care D-200.982

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

Creating an Effective Environment for Medical Student Education H-295.900

1. The AMA encourages the development of a model student orientation program that includes workshops that address health awareness for students and standards of behavior for teachers and learners.

2. Our AMA will: (A) ask the Liaison Committee on Medical Education to ensure that medical schools have policies to protect medical students from retaliation based on reporting incidents of mistreatment; and (B) through the Learning Environment Study, conduct research and disseminate findings on the medical education learning environment including the positive and negative elements of that environment that impact the teacher-learner relationship; and (C) encourage the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to identify best practices and strategies to assure an appropriate learning environment for medical students.

Medical Student Health and Well-Being H-295.927

The AMA encourages the Association of American Medical Colleges, Liaison Committee on Medical Education, medical schools, and teaching hospitals to address issues related to the health and well-being of medical students, with particular attention to issues such as HIV infection that may have long-term implications for health, disability and medical practice, and consider the feasibility of financial assistance for students with disabilities.

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.

**Teacher-Learner Relationship In Medical Education H-295.955**

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

**CODE OF BEHAVIOR**

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral
level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.

Insurance Coverage for Medical Students and Resident Physicians H-295.942

The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical
schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance.

**Due Process H-295.998**

(1) Our AMA reaffirms its 1974 approval of the policy adopted by the Liaison Committee on Medical Education, which states: “A medical school should develop and publicize to its faculty and students a clear definition of its procedures for the evaluation, advancement, and graduation of students. Principles of fairness and ‘due process’ must apply when considering actions of the faculty or administration which will adversely affect the student to deprive him of his valuable rights.”

(2) In addition, to clarify and protect the rights of medical students, the AMA recommends that: (a) Each school develop and publish in its catalog, student handbook or similar publication the institutional policies and procedures both for evaluation of academic performance (promotion, graduation, dismissal, probation, remedial work, and the like) and for nonacademic disciplinary decisions. (b) These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and written notification to the student that his/her academic/nonacademic performance is in question, and provide an opportunity for the student to learn why it has been questioned. (c) These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, he/she has adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce his/her own data. (d) The student should be allowed to be accompanied by a student or faculty advisor. (e) The policies and procedures should include an appeal mechanism within the medical school. (f) The student should be allowed to continue in the academic program during the proceedings unless extraordinary circumstances exist, such as physical threat to others.

**Discriminatory Questions on Applications for Medical Licensure D-295.319**

Our American Medical Association will work with the Federation of State Medical Boards and other appropriate stakeholders to develop model language for medical licensure applications which is non discriminatory and which does not create barriers to appropriate diagnosis and treatment of psychiatric disorders, consistent with the responsibility of state medical boards to protect the public health.

**Self-Incriminating Questions on Applications for Licensure and Specialty Boards H-275.945**
The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked.

Continued Support for Diversity in Medical Education D-295.963

1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.

2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.

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.

Enhancing Accommodations for People with Disabilities H-90.971

Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

Remediation Programs for Physicians D-295.325
1. Our AMA supports the efforts of the Federation of State Medical Boards (FSMB) to maintain an accessible national repository on remediation programs that provides information to interested stakeholders and allows the medical profession to study the issue on a national level.

2. Our AMA will collaborate with other appropriate organizations, such as the FSMB and the Association of American Medical Colleges, to study and develop effective methods and tools to assess the effectiveness of physician remediation programs, especially the relationship between program outcomes and the quality of patient care.

3. Our AMA supports efforts to remove barriers to assessment programs including cost and accessibility to physicians.

4. Our AMA will partner with the FSMB and state medical licensing boards, hospitals, professional societies and other stakeholders in efforts to support the development of consistent standards and programs for remediating deficits in physician knowledge and skills.

5. Our AMA will ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to develop standards that would encourage medical education programs to engage in early identification and remediation of conditions, such as learning disabilities, that could lead to later knowledge and skill deficits in practicing physicians.

Medical Staff Development Plans H-225.961

1. All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex,
race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, gender identity or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals.

2. The AMA communicates the medical staff development plan principles to the President and Chair of the Board of the American Hospital Association and recommend that state and local medical associations establish a dialogue regarding medical staff development plans with their state hospital association.

Relevant AMA-MSS Policy:

Availability of Medical Education 295.005MSS

AMA-MSS supports the following principles: (1) A determined, conscientious effort to accept, matriculate, and graduate minority physicians must be undertaken. (2) Support for programs with a commitment to the training of minority medical professionals, particularly the three predominantly black medical schools (Howard, Meharry, Morehouse) must be increased as necessary and maintained. (3) Adequate financial aid packages for minority students must be provided. These may include combinations of grants, loans, scholarships, or service- obligated programs. (4) Efforts should be made to increase the proportion of minorities in medical school faculties and administrative positions. (5) Efforts must be made to improve retention rates of minority students in medical schools.

Funding for Affirmative Action Programs 350.004MSS

AMA-MSS will ask the AMA to: (1) support counseling and intervention designed to increase minority enrollment, retention, and graduation of medical students; and (2) support increased funding appropriations to DHHS Health Careers Opportunities Program.

Minority Representation in the Medical Profession 350.003MSS

AMA-MSS will ask the AMA to: (1) support Affirmative Action in recruitment, retention, and graduation of minorities by all medical schools; and (2) urge private sources and federal and state governments to ensure sufficient funding to support increases in minority and economically disadvantaged student representation in medical schools.

The Disadvantaged Minority Health Improvement Act of 1989 350.011MSS

AMA-MSS publicly states and reaffirms and will ask the AMA to publicly state and reaffirm its stance on diversity in medical education and its strong opposition to the reduction of opportunities used to increase the number of minority and premedical students in training.

Dissemination of Disability Insurance Information 295.074MSS
AMA-MSS encourages medical schools to widely disseminate information to medical students regarding disability insurance and available policy options.

**Expansion of Student Health Services 295.137MSS**

AMA-MSS will ask the AMA to: (1) strongly encourage all medical schools to establish student health centers in order to provide adequate and timely medical and mental health care to their students; and (2) encourage medical schools to increase their student health center’s hours to include weekend coverage.

**Adequate Insurance for Medical Students and Residents 295.027MSS**

AMA-MSS will ask the AMA to: (1) urge all medical schools to pay for or offer affordable, policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) urge all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) urge medical schools and residency training programs to pay for or offer affordable health insurance to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) urge carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting.

**Medical Student Access to Comprehensive Mental Health and Substance Abuse Treatment 295.164MSS**

AMA-MSS strongly encourages the Association of American Medical Colleges and the Liaison Committee on Medical Education to conduct research into the number of US medical students with mental health and/or substance abuse concerns who either: 1. do not seek treatment due to the cost involved, or 2. have sought treatment, but do not feel that it has been adequate due to yearly visit and dollar limits placed on their care by their insurance plan.

**Societal Discrepancies in the Disabled Population and Post-Secondary Disability Resource Center Utilization 90.007MSS**

AMA-MSS (1) supports educating medical students and health care professionals on the societal discrepancies endured by the disabled population as well as services provided by post-secondary disability resource centers; and (2) will promote utilization of disability resource centers at the post-secondary level for students who meet the requirements established by those centers.

**Student Workhour Reform 295.063MSS**
AMA-MSS will ask the AMA to work diligently toward medical education reform that will train its future physicians in a more effective and humanistic environment.

**Support Groups 295.001MSS**

AMA-MSS will ask the AMA to encourage the development of alternative methods for dealing with the problems of student-physician mental health in medical schools and that these alternatives be available to students at the earliest possible point in their medical education.

**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.

**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.

**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.

**Policy Regarding HIV Infected Medical Students 20.012MSS**

AMA-MSS will ask the AMA to take the stand that a medical student who becomes infected with human immunodeficiency virus (HIV) and other blood-borne infectious diseases should not be prevented from completing his or her course of study and receiving their MD/DO degree based solely on their HIV seropositivity.

**Public Image of Physicians 445.001MSS**

AMA-MSS: (a) will help develop community service and public education programs that serve to inform the public of health care issues and improve the public image of the AMA and the medical profession; and (b) will investigate possible advantages of involving medical students in
AMA efforts to improve the public image of physicians and to assure the public that the primary role of physicians today continues to be that of advocates for their patient's health.

**Cultural Competency Training For Medical School Faculty, Staff, and Students Concerning Individuals Who Are Lesbian, Gay, Bisexual, Transgender, Gender Nonconforming, and/or Born with Differences of Sexual Development 295.190MSS**

Our AMA-MSS (1) supports the development and implementation of cultural competency programs by medical schools that train and guide medical school faculty, staff, and students in effective and compassionate communication with individuals of different backgrounds, including but not limited to gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age; and (2) support the development and implementation of supportive programs and confidential counseling services by medical schools to individuals within their institutions who have faced challenges due to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age.
Whereas, The American Medical Association (AMA) (H-315.969), American Association of Medical Colleges (AAMC),1,2 Liaison Committee on Medical Education (LCME),3 Alliance for Clinical Education (ACE),4 the American Association of Colleges of Osteopathic Medicine (AACOM),5 and the American Osteopathic Association (AOA)6 support the acquisition of hands-on experience in documenting patient encounters and entering clinical orders into patients' electronic health records, with appropriate supervision; and

Whereas, Our AMA recognizes that burnout is a problem among physicians (D-310.968) and clinical documentation has been shown to increase the rate of physician burnout7,8,9; and

Whereas, The largest barriers to electronic health record (EHR) access and documentation by medical students have been restrictive medical school/hospital rules, concern for liability (435.007MSS), and inability for notes to support medical billing10,11,12; and

1 Association of American Medical Colleges. Core Entrustable Professional Activities for Entering Residency. 2014.
Whereas, Medical students are typically protected under a general liability policy purchased by medical schools similar to protection afforded to mid level providers and where final decision making is made under supervision of a licensed physicians to maintain standard of conduct; and

Whereas, As of March 5, 2018, medical students have been approved by Centers for Medicare & Medicaid Services (CMS) to document patient visits as part of evaluation and management in the electronic health record system without the need for redocumentation by physicians for the patient medical history excluding the physical exam and medical decision making; potentially enabling the potential for medical students to be remunerated for this task; and

Whereas, Decreasing medical student debt and combating tuition increases are a priority of our AMA (D-305.970, D-305.975, D-305.978, D-305.983, D-305.993, H-305.928, H-305.929, H-305.988, 305.004MSS, 305.010MSS, 305.037MSS, 305.046MSS, 305.057MSS); and

Whereas, Our AMA supports increasing sources of funding and financial aid in an effort to increase the number of minority and economically disadvantaged student representation in medical schools (295.005MSS & 305.003MSS); and

Whereas, There is a projected shortfall of primary care physicians (PCPs) that has been associated with accrual of medical education debt; and

Whereas, Evaluation and management documentation occurs often in the primary care setting; as such, providing a debt reduction mechanism that incorporates documentation may stimulate PCP growth and save attendings valuable time; and


Friedman E, Sainte M, Fallar R. Taking note of the perceived value and impact of medical student chart documentation on education and patient care. Acad Med. 2010;85(9):1440-1444. doi:10.1097/ACM.0b013e3181eac1e0


Kahn MJ, Sneed EJ. Promoting the affordability of medical education to groups underrepresented in the profession: the other side of the equation. AMA J ethics. 2015;17(2):176-180. doi:10.1001/virtualmentor.2015.17.02.oped1-1502


Whereas, There are many examples of compensated non-physician health-care professionals performing scribe or electronic health record documentation and working under the supervision and final approval of a licensed physician including medical scribes, medical assistants, nurses, and physician assistants which may apply to medical students (H-360.988, H-360.987, H-385.939, H-305.928); and

Whereas, Similar to scribes, medical students can add value through documentation by decreasing physician time on EHR, increasing physician time for complex care, or increasing captured revenue by enhancing documentation compliance, and patient satisfaction (D-70.979, H-295.864, H-70.952, & H-385.952); and

Whereas, Assuming a medical student carries 3 patients per day on outpatient or inpatient medicine (CPT 99212, 99202, 99221), generates time for a physician to see 1 complex patient (CPT 99214, 99204, 99223), and is credited with ⅔ of the billing for documentation completed for 3 visits for a five day work week for 48 weeks, then total billable credit for the student ranges from $21,000 to $49,000 with a profit of $15,000 to $24,000 created for the physician; and

Whereas, The annual cost of medical education on average is $35,932 - $60,543 depending on public/private/residency status; and

Whereas, Medical students, residents, and physicians currently routinely spend up to 40% of clinical time in the electronic health record and STEP 2 CS has a similar allotment of time; and

Whereas, Funds potentially can be accrued as a tax deductible donation to a scholarship fund which is credited at the end of the fiscal year to students accounts limiting tax liability for students, and creating tax incentives for participating providers as a donation (H-305.934, H-305.935, H-305.960).

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305.962, 305.025MSS, & 305.066MSS), providing a suitable mechanism for distribution of funds for education; therefore be it

RESOLVED, That our AMA advocate for tuition reimbursement to medical students for documentation in the electronic health record, as permitted by Centers for Medicare & Medicaid Services (CMS) Medicare Claims Processing Manual and/or other payors, during their clinical clerkships; and be it further

RESOLVED, That our AMA collaborate with appropriate stakeholders to study and implement best practice mechanisms of tuition reimbursement fund accrual and distribution including but not limited to tax deductible donations from healthcare facilities to medical schools for tuition reduction; and be it further

RESOLVED, That our AMA collaborate with appropriate stakeholders to develop reasonable limitations on the number of notes a medical student may author so as not to create financial incentives that jeopardize medical student education and training; and be it further

RESOLVED, That our AMA amend current Policy D-305.970 by addition to read as follows:

Proposed Revisions to AMA Policy on Medical Student Debt, D-305.970

1. Collaborate, based on AMA policy, with members of the Federation and the medical education community, and with other interested organizations, to achieve the following immediate public- and private-sector advocacy goals:
   (a) Support expansion of and adequate funding for federal scholarship and loan repayment programs, such as those from the National Health Service Corps, the Indian Health Service, the Armed Forces, and the Department of Veterans Affairs, and for comparable programs at the state level.
   (b) Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
   (c) With each reauthorization of the Higher Education Act and at every other legislative opportunity, proactively pursue loan consolidation terms that favor students and ensure that loan deferment is available for the entire duration of residency and fellowship training.
   (d) Ensure that the Higher Education Act and other legislation allow interest from medical student loans to be fully tax deductible.
   (e) Encourage medical schools, with the support of the Federation, to engage in fundraising activities devoted to increasing the availability of scholarship support.
   (f) Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
   (g) Support stable funding for medical education programs to limit excessive tuition increases.
   (h) Advocate for medical students to receive tuition reimbursement for performing electronic health record Documentation as a part of Evaluation and Management

2. Encourage medical schools to study the costs and benefits associated with
non-traditional instructional formats (such as online and distance learning, combined baccalaureate/MD programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education.

RESOLVED, That our AMA amend current Policy D-305.975 by addition to read as follows:

Long-Term Solutions to Medical Student Debt, D-305.975

Our AMA will: (1) encourage medical schools and state medical societies to consider the creation of self-managed, low-interest loan programs for medical students, and collect and disseminate information on such programs; (2) advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas; (3) work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment; (4) collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided; and (5) encourage the National Health Services Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas; and (6) strongly advocate for tuition reimbursement for medical student performed electronic health record documentation as a part of Evaluation and Management.

RESOLVED, That our AMA amend current Policy D-305.993 by addition to read as follows:

Medical School Financing, Tuition, and Student Debt, D-305.993

1. The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of developing 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 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.

8. Our AMA will advocate against putting a monetary cap on federal loan forgiveness programs.

9. Our AMA will: (a) advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; (b) work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be at least equal to the principal amount borrowed; and (c) ask the United States Department of Education to include all terms of Public Service Loan Forgiveness in the contractual obligations of the Master Promissory Note.

10. Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to require programs to include within the terms, conditions, and benefits of appointment to the program (which must be provided to applicants invited to interview, as per ACGME Institutional Requirements) information regarding the Public Service Loan Forgiveness (PSLF) program qualifying status of the employer.

11. Our AMA will advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility.

12. Our AMA encourages medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.

13. Our AMA encourages medical school financial advisors to promote to medical students service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.
14. Our AMA will strongly advocate that the terms of the PSLF that existed at the
time of the agreement remain unchanged for any program participant in the event
of any future restrictive changes.
15. Our AMA will strongly advocate for tuition reimbursement for medical student
performed electronic health record documentation as a part of Evaluation and
Management.

RESOLVED, That our AMA amend current Policy H-305.928 by addition to read as follows:

Proposed Revisions to AMA Policy on Medical Student Debt H-305.928

1. Our AMA will make reducing medical student debt a high priority for legislative
and other action and will collaborate with other organizations to study how costs
to students of medical education can be reduced.
2. Our AMA supports stable funding for medical schools to eliminate the need for
increases in tuition and fees to compensate for unanticipated decreases in other
sources of revenue and should oppose mid-year and retroactive tuition
increases.
3. Financial aid opportunities, including scholarship and loan repayment
programs, should be available so that individuals are not denied an opportunity to
pursue medical education because of financial constraints.
4. A sufficient breadth of financial aid opportunities should be available so that
student specialty choice is not constrained based on the need for financial
assistance.
5. Our AMA supports the creation of new and the expansion of existing medical
education financial assistance programs from the federal government, the states,
and the private sector.
6. Medical schools should have programs in place to assist students to limit their
debt. This includes making scholarship support available, counseling students
about financial aid availability, and providing comprehensive debt
management/financial planning counseling.
7. Our AMA supports legislation and regulation that would result in favorable
terms and conditions for borrowing and for loan repayment, and would permit the
full deductibility of interest on student loans.
8. Medical students should not be forced to jeopardize their education by the
need to seek employment. Any decision on the part of the medical student to
seek employment should take into account his/her academic situation. Medical
schools should have policies and procedures in place that allow for flexible
scheduling in the case that medical students encounter financial difficulties that
can be remedied only by employment. Medical schools should consider creating
opportunities for paid employment for medical students, including but not limited
to tuition reimbursement for medical student performed electronic health record
documentation as a part of Evaluation and Management.

RESOLVED, That our AMA amend Policy H-315.969 by insertion and deletion as follows:

Medical Student Access to Electronic Health Records, H-315.969
Our AMA: (1) recognizes the educational benefits of medical student access to electronic health record (EHR) systems as part of their clinical training; (2) encourages medical schools, teaching hospitals, and physicians practices used for clinical education to utilize clinical information systems that permit students to both read and enter information into the EHR, as an important part of the patient care team contributing clinically relevant information; (3) encourages research on and the dissemination of available information about ways to overcome barriers and facilitate appropriate medical student access to EHRs and advocate to the Electronic Health Record Vendors Association that all Electronic Health Record vendors incorporate appropriate medical student access to EHRs; (4) supports medical student acquisition of hands-on experience in documenting patient encounters and entering clinical orders into patients' electronic health records (EHRs), with appropriate supervision, as was the case with paper charting, with appropriate supervision as outlined by guidance from The Centers for Medicare & Medicaid Services and/or other payors, and advocates for medical students to be reimbursed appropriately for this documentation work; (5) (A) will research the key elements recommended for an educational Electronic Health Record (EHR) platform; and (B) based on the research—including the outcomes from the Accelerating Change in Medical Education initiatives to integrate EHR-based instruction and assessment into undergraduate medical education—determine the characteristics of an ideal software system that should be incorporated for use in clinical settings at medical schools and teaching hospitals that offer EHR educational programs; (6) encourage efforts to incorporate EHR training into undergraduate medical education, including the technical and ethical aspects of their use, under the appropriate level of supervision; and (7) will work with the Liaison Committee for Medical Education (LCME), AOA Commission on Osteopathic College Accreditation (COCA) and the Accreditation Council for Graduate Medical Education (ACGME) to encourage the nation's medical schools and residency and fellowship training programs to teach students and trainees effective methods of utilizing electronic devices in the exam room and at the bedside to enhance rather than impede the physician-patient relationship and improve patient care.

RESOLVED, That our AMA-MSS amend current Policy 295.126MSS by addition to read as follows:

Medical Student Clinical Training and Education Conditions, 295.126MSS

AMA-MSS will ask the AMA to: (1) commend the LCME for addressing the issue of the medical student learning environment including student clerkship hours; (2) urge the LCME to adopt specific medical student clinical training and educational guidelines for the clerkship years including: (a) No more than one night on call every three nights; (b) No more than 80 hours total of clinical training and education time per week averaged over four weeks; and (c) No more than 24 consecutive hours on call (d) No more than 40% of clinical training time can be spent completing electronic health record documentation; and (2) recommend
that the LCME revisit the issue of medical student clinical training and education conditions every five years for revision.

RESOLVED, That our AMA-MSS amend Policy 305.053MSS by insertion as follows:

Expanding and Strengthening AMA Advocacy on Medical Student Debt, 305.053MSS

(1) AMA-MSS will ask the AMA to lobby for passage of legislation that would (a) eliminate the cap on the student loan interest deduction, (b) increase the income limits for taking the interest deduction, (c) include room and board expenses in the definition of tax-exempt scholarship income, and (d) make permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (2) AMA-MSS will ask the AMA to support and encourage our state medical societies to support further expansion of state loan repayment programs, and in particular expansion of those programs to cover physicians in non-primary-care specialties; (3) AMA-MSS will ask the AMA to advocate for medical students to receive tuition reimbursement for performing electronic health record documentation as a part of Evaluation and Management (MSS Res 6, I-03) (AMA Res 850, 848, and 847, I-03 Adopted [D-305.980, D-305.982, D-305.979]) (Reaffirmed: MSS Res 3, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Modified: MSS GC Rep D, I-15)

RESOLVED, That our AMA-MSS amend Policy 305.058MSS by insertion as follows:

AMA-MSS Medical Student Loan & Financial Aid Online Education Resource, 305.058MSS

(1) AMA-MSS will ask the AMA to reaffirm AMA Policies H-305.989 and H-305.996. (2) AMA-MSS will request that each medical school provide to the MSS its own up to date online resource explaining prior to enrollment its loan disbursement procedures, and any private loans the school may offer, and whether or not they offer tuition reimbursement to medical students for performing electronic health record documentation as a part of Evaluation and Management (MSS Sub Res 1, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

RESOLVED, That our AMA-MSS amend Policy 305.073MSS by insertion as follows:

Transparency in Medical Student Financial Aid Reporting, 305.073MSS

AMA-MSS will ask the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine to require greater transparency in financial aid information provided to medical students and applicants by encouraging medical colleges to provide additional data to students and applicants including but not limited to: (1) average debt incurred in medical school for graduating students with federal aid assistance, separated by in-state and out-of-state students, reported in quartiles (2) percent of current students
receiving financial aid other than loans, and (3) the amount and types of available non-loan aid such as scholarships, interest-free loans, or grants available from the institution, or tuition reimbursement for performing electronic health record documentation as a part of Evaluation and Management available from the institution. (MSS Res 1, A-12)
RELEVANT AMA AND AMA-MSS POLICY

Medical Student Access to Electronic Health Records H-315.969
Our AMA: (1) recognizes the educational benefits of medical student access to electronic health record (EHR) systems as part of their clinical training; (2) encourages medical schools, teaching hospitals, and physicians practices used for clinical education to utilize clinical information systems that permit students to both read and enter information into the EHR, as an important part of the patient care team contributing clinically relevant information; (3) encourages research on and the dissemination of available information about ways to overcome barriers and facilitate appropriate medical student access to EHRs and advocate to the Electronic Health Record Vendors Association that all Electronic Health Record vendors incorporate appropriate medical student access to EHRs; (4) supports medical student acquisition of hands-on experience in documenting patient encounters and entering clinical orders into patients' electronic health records (EHRs), with appropriate supervision, as was the case with paper charting; (5) (A) will research the key elements recommended for an educational Electronic Health Record (EHR) platform; and (B) based on the research--including the outcomes from the Accelerating Change in Medical Education initiatives to integrate EHR-based instruction and assessment into undergraduate medical education--determine the characteristics of an ideal software system that should be incorporated for use in clinical settings at medical schools and teaching hospitals that offer EHR educational programs; (6) encourage efforts to incorporate EHR training into undergraduate medical education, including the technical and ethical aspects of their use, under the appropriate level of supervision; and (7) will work with the Liaison Committee for Medical Education(LCME), AOA Commission on Osteopathic College Accreditation (COCA) and the Accreditation Council for Graduate Medical Education (ACGME) to encourage the nation's medical schools and residency and fellowship training programs to teach students and trainees effective methods of utilizing electronic devices in the exam room and at the bedside to enhance rather than impede the physician-patient relationship and improve patient care.

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.

**Proposed Revisions to AMA Policy on Medical Student Debt D-305.970**

1. Collaborate, based on AMA policy, with members of the Federation and the medical education community, and with other interested organizations, to achieve the following immediate public- and private-sector advocacy goals:

   (a) Support expansion of and adequate funding for federal scholarship and loan repayment programs, such as those from the National Health Service Corps, the Indian Health Service, the Armed Forces, and the Department of Veterans Affairs, and for comparable programs at the state level.

   (b) Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.

   (c) With each reauthorization of the Higher Education Act and at every other legislative opportunity, proactively pursue loan consolidation terms that favor students and ensure that loan deferment is available for the entire duration of residency and fellowship training.

   (d) Ensure that the Higher Education Act and other legislation allow interest from medical student loans to be fully tax deductible.

   (e) Encourage medical schools, with the support of the Federation, to engage in fundraising activities devoted to increasing the availability of scholarship support.

   (f) Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).

   (g) Support stable funding for medical education programs to limit excessive tuition increases.

2. Encourage medical schools to study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, combined baccalaureate/MD programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education.

**Long-Term Solutions to Medical Student Debt D-305.975**

Our AMA will: (1) encourage medical schools and state medical societies to consider the creation of self-managed, low-interest loan programs for medical students, and collect and disseminate information on such programs; (2) advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas; (3) work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment; (4) collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided; and (5) encourage the National Health Services Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
Mechanisms to Reduce Medical Student Debt D-305.978
(1) take an active advocacy role during the upcoming reauthorization of the Higher Education Act and other pending legislation, to achieve the following goals: (a) eliminating the single holder rule, (b) making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training, (c) retaining the option of loan forbearance for residents ineligible for loan deferment, (d) including, explicitly, dependent care expenses in the definition of the "cost of attendance," (e) including room and board expenses in the definition of tax-exempt scholarship income, (f) continuing the loan consolidation program, including the ability to "lock in" a fixed interest rate, and (g) adding the ability to refinance Federal Consolidation Loans;
(2) continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases;
(3) encourage members of the Federation to develop or enhance financial aid opportunities for medical students;
(4) continue to monitor the availability of financial aid opportunities and financial planning/debt management counseling at medical schools, and share innovative approaches with the medical education community;
(5) continue to collect and disseminate information to assist members of the Federation (state medical societies and specialty societies) and medical schools to establish or expand financial aid programs; and
(6) continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students.

Strategies to Combat Mid-year and Retroactive Tuition Increases D-305.983
Our AMA will: (1) assist state medical societies in advocacy efforts in opposition to mid-year and retroactive tuition increases; (2) make available, upon request, the judicial precedent that would support a successful legal challenge to mid-year tuition increases; and (3) continue to encourage individual medical schools and universities, federal and state agencies, and others to expand options and opportunities for financial aid to medical students.

Medical School Financing, Tuition, and Student Debt D-305.993
1. The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of developing 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 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.
8. Our AMA will advocate against putting a monetary cap on federal loan forgiveness programs.
9. Our AMA will: (a) advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; (b) work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be at least equal to the principal amount borrowed; and (c) ask the United States Department of Education to include all terms of Public Service Loan Forgiveness in the contractual obligations of the Master Promissory Note.
10. Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to require programs to include within the terms, conditions, and benefits of appointment to the program (which must be provided to applicants invited to interview, as per ACGME Institutional Requirements) information regarding the Public Service Loan Forgiveness (PSLF) program qualifying status of the employer.
11. Our AMA will advocate that the profit status of a physician’s training institution not be a factor for PSLF eligibility.
12. Our AMA encourages medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.
13. Our AMA encourages medical school financial advisors to promote to medical students service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.
14. Our AMA will strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

**Proposed Revisions to AMA Policy on Medical Student Debt H-305.928**
1. Our AMA will make reducing medical student debt a high priority for legislative and other action and will collaborate with other organizations to study how costs to students of medical education can be reduced.
2. Our AMA supports stable funding for medical schools to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue and should oppose mid-year and retroactive tuition increases.
3. Financial aid opportunities, including scholarship and loan repayment programs, should be available so that individuals are not denied an opportunity to pursue medical education because of financial constraints.

4. A sufficient breadth of financial aid opportunities should be available so that student specialty choice is not constrained based on the need for financial assistance.

5. Our AMA supports the creation of new and the expansion of existing medical education financial assistance programs from the federal government, the states, and the private sector.

6. Medical schools should have programs in place to assist students to limit their debt. This includes making scholarship support available, counseling students about financial aid availability, and providing comprehensive debt management/financial planning counseling.

7. Our AMA supports legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit the full deductibility of interest on student loans.

8. Medical students should not be forced to jeopardize their education by the need to seek employment. Any decision on the part of the medical student to seek employment should take into account his/her academic situation. Medical schools should have policies and procedures in place that allow for flexible scheduling in the case that medical students encounter financial difficulties that can be remedied only by employment. Medical schools should consider creating opportunities for paid employment for medical students.

9. Financial obligations, such as repayment of loans, and service obligations made in exchange for financial assistance, should be fulfilled. There should be mechanisms to assist physicians who are experiencing hardship in meeting these obligations.

10. Our AMA supports the expansion and increase of medical student and physician benefits under Public Service Loan Forgiveness.

11. Our AMA opposes any stipulations in loan repayment programs that place greater burdens upon married couples than for similarly-situated couples who are cohabitating.

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.

Cost and Financing of Medical Education and Availability of First-Year Residency Positions H-305.988

1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;

2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;

3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;

4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;

5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;

6. supports continued study of the relationship between medical student indebtedness and career choice;

7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract
students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.

Preservation of Five Levels of Evaluation and Management Services D-70.979
Our AMA will communicate to the Centers for Medicare and Medicaid Services and to private payers that the current levels of Evaluation and Management services should be maintained and not compressed, with appropriate payment for each level.

Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians H-295.864
Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; interprofessional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes.

Appropriate Physician Reimbursement by Centers for Medicare & Medicaid Services H-385.952
Our AMA: (1) opposes both CMS's and local carriers' efforts to reduce or deny physician payments for appropriate services; and (2) will work to assure that all evaluation and management services are appropriately reimbursed.

Medical School Tuition and Opposition to Tax Increases H-305.934
1. Our American Medical Association opposes the imposition of mid-year and retroactive tuition increases at both public and private medical schools. 2. Our AMA opposes tuition taxes and any other attendance-based taxes by any government entity.

Taxation of Federal Student Aid H-305.962
Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA).

**Preservation of Evaluation/Management CPT Codes H-70.985**

It is the policy of the AMA to (1) oppose the bundling of procedure and laboratory services within the current CPT Evaluation/Management (E/M) services; (2) oppose the compression of E/M codes and support efforts to better define and delineate such services and their codes; (3) seek feedback from its members on insurance practices that advocate bundling of procedures and laboratory services with or the compression of codes in the CPT E/M codes, and express its views to such companies on behalf of its members; (4) continue to work with the PPRC and all other appropriate organizations to insure that any modifications of CPT E/M codes are appropriate, clinically meaningful, and reflective of the considered views of organized medicine; and (5) work to ensure that physicians have the continued opportunity to use CPT as a coding system that is maintained by the medical profession.

**Federal Intervention in the Setting of Educational Standards H-295.921**

The AMA strongly opposes federal intervention, through legislative restrictions, that would limit the authority of professional accrediting bodies to design and implement appropriate educational standards for the training of physicians. The AMA strongly opposes infringements and mandates on medical school curricular requirements through state and federal legislative efforts, and also recommends that state medical societies should carefully monitor such activities and notify the AMA when such intrusions take place.

**Study of Minimum Competencies and Scope of Medical Scribe Utilization D-478.967**

Our AMA will monitor the medical scribe industry periodically to identify important trends and will continue to review and promote strategies that help improve physician practice workflow.

**Physician Assistants and Nurse Practitioners H-160.947**

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

1. The physician is responsible for managing the health care of patients in all settings.
2. Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
3. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
4. The physician is responsible for the supervision of the physician assistant in all settings.
5. The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
6. The physician must be available for consultation with the physician assistant at all times,
either in person or through telecommunication systems or other means.

(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.

(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.

(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.

(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.

**Nurse Practitioner Reimbursement Under Medicare H-360.988**

Our AMA supports provision of payment to the employing physician for all services provided by physician assistants and nurse practitioners under the physician's supervision and direction regardless of whether such services are performed where the physician is physically present, so long as the ultimate responsibility for these services rests with the physician and so long as the services are provided in conformance with applicable state laws. With regard to physician assistants, such supervision in most settings includes the personal presence or participation of the physician. In certain practice settings where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, appropriate site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times.

**Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice H-360.987**

Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.

(2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.

(3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.

(4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.

(5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities.

(6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.

**Hospital Billing on Behalf of Physicians H-385.939**

Our AMA: (1) advocates that personnel performing diagnostic and procedural coding of physicians' services provide that information, including itemized billing information, collection rates, procedures, and remittance information, to those physicians providing the coded services;
(2) urges physicians to participate in the processes used by entities submitting claims for and receiving payment on behalf of physicians; (3) urges that any entity billing for physicians' services ensure that, when a physician's choice of CPT code has been changed, the physician be so notified and the recoder identified before submission of a bill; (4) encourages physicians to carefully evaluate their billing procedures upon selling their practice or contracting for billing services; (5) encourages physicians to establish billing practice policies and billing compliance programs that include monitoring and reviewing billing accuracy; and (6) encourages physicians who sell their practice or contract out billing services to establish a mechanism for continually reviewing the collection methods and procedures of the billing entity.

**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 make available the findings of the AmericanEHR Partners' survey and report back to the House of Delegates.

**Medicare Guidelines for Evaluation and Management Codes H-70.952**

Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services; (2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse; (3) urges CMS to adequately fund Medicare Carrier distribution of any documentation guidelines and provide funding to Carriers to sponsor educational efforts for physicians; (4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately reflected in the Resource Based Relative Value Scale (RBRVS); (5) will facilitate review and corrective action regarding the excessive content of the evaluation and management documentation guidelines in collaboration with the national medical specialty societies and to work to suspend implementation of all single system examination guidelines until approved by the national medical specialty societies affected by such guidelines, (6) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS, (7) urges CMS to establish a test period in a specific geographic region for these new guidelines.
to determine any effect their implementation will have on quality patient care, cost effectiveness and efficiency of delivery prior to enforcement of these mandated regulations;

(8) opposes adoption of the Medicare evaluation and management documentation guidelines for inclusion in the CPT; and

(9) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required.

Transparency In Medical Schools' Utilization of Funds From Tuition and Fee Increases D-295.933
Our AMA encourages the development of policies by Liaison Committee on Medical Education- and American Osteopathic Association-accredited medical schools that ensure information on the use of funds from tuition and fee increases is disclosed in a standardized format and in a timely manner to prospective and current medical students.

435.007MSS U.S. Medical Liability Crisis and the Impact on Clinical Medical Education:
AMA-MSS will ask the AMA to: (1) recognize that undergraduate and graduate medical education are impacted by the medical liability crisis; and (2) oppose medical liability insurance premiums based solely on preceptor or volunteer faculty status (MSS Res 5, A-04) (AMA Res 909, I04) (Modified: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

305.004MSS Medical School Admission Policies:
AMA-MSS will ask the AMA to: (1) support medical school admission policies that do not discriminate against students who may require financial aid to pursue a medical education; (2) encourage all US medical schools to adopt an active policy of informing medical school applicants of estimated tuition and fees for each year of undergraduate medical education and of the sources of financial aid available; and (3) continue to encourage the maintenance and development of resources, both public and private, to help meet the financial needs of students attending American medical schools. (AMA Res 142, A-81 Referred) (BOT Amended Rep JJ, I-81 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)

305.010MSS Medical School Tuition
AMA-MSS endorses the concept that medical schools should guarantee that tuition will not be raised by more than a certain modest percentage for students already enrolled and that any additional tuition increases that may be necessary should be imposed on the entering class. (MSS Rep H, A-82) (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)

305.037MSS Medical School Tuition:
The AMA-MSS Governing Council will continue to work with AMA staff to ensure student concerns on indebtedness and medical school tuition are addressed in all health system reform legislation. (MSS Sub Res 27, I-93) (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)

305.046MSS Mid-Year and Retroactive Medical School Tuition Increases:
AMA-MSS will ask the AMA to: (1) work with the AAMC to discourage assessment of mid-year and retroactive increases in medical school tuition and fees; and (2) encourage state and county medical societies to develop policy and lobby state legislatures to help restrain medical school tuition increases. (MSS Amended Late Res 2, I-01) (AMA Amended Res 312, I-01 Adopted [D-295.978]) (Reaffirmed: MSS Res F, I-06) (Reaffirmed: MSS Res D, I-11) (D-295.978 Rescinded: CME Rep. 2, A-11) (Reaffirmed: MSS GC Report A, I-16)

305.057MSS Legal Injunction on Medical School Tuition Increases:
AMA-MSS supports and will ask the AMA to support the use of legal injunctions to block mid-year and retroactive medical school tuition or fee increases. (MSS Res Late 1, I-04) (AMA Res 833, I-04 Referred) (Modified: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

295.005MSS Availability of Medical Education: AMA-MSS supports the following principles:
(1) A determined, conscientious effort to accept, matriculate, and graduate minority physicians must be undertaken. (2) Support for programs with a commitment to the training of minority medical professionals, particularly the three predominantly black medical schools (Howard, Meharry, Morehouse) must be increased as necessary and maintained. (3) Adequate financial aid packages for minority students must be provided. These may include combinations of grants, loans, scholarships, or service obligated programs. (4) Efforts should be made to increase the proportion of minorities in medical school faculties and administrative positions. (5) Efforts must be made to improve retention rates of minority students in medical schools. (MSS Position Paper 2, A-83) (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)

350.003MSS Minority Representation in the Medical Profession:
AMA-MSS will ask the AMA to: (1) support Affirmative Action in recruitment, retention, and graduation of minorities by all medical schools; and (2) urge private sources and federal and state governments to ensure sufficient funding to support increases in minority and economically disadvantaged student representation in medical schools. (AMA Res 85, I-81, Referred) (CME Rep C, A-82 Adopted in Lieu of AMA Res 85, I-81) (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 Report D, I-15)

305.025MSS Taxation of Federal Student Aid:
AMA-MSS will ask the AMA to oppose legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA). (AMA Res 210, I-91 Adopted [H-305.962]) (Reaffirmed: MSS Res B, I-00) (Reaffirmed: MSS Res E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

305.066MSS Opposition to Tuition Taxes:
AMA-MSS opposes, and will ask the AMA to oppose, medical school tuition taxes and any other attendance-based taxes imposed on medical students by any government entity. (MSS Res 3, A-10) (AMA Amended Res 905, I-10 Adopted [H305.934]) (Reaffirmed, MSS GC Rep D, I-15)

295.126MSS Medical Student Clinical Training and Education Conditions:
AMA-MSS will ask the AMA to: (1) commend the LCME for addressing the issue of the medical student learning environment including student clerkship hours; (2) urge the LCME to adopt specific medical student clinical training and educational guidelines for the clerkship years including: (a) No more than one night on call every three nights; (b) No more than 80 hours total of clinical training and education time per week averaged over four weeks; and (c) No more than 24 consecutive hours on call; and (2) recommend that the LCME revisit the issue of medical student clinical training and education conditions every five years for revision. (MSS Res 16, I-03 Referred) (AMA Res 310, A-04 Referred) (Reaffirmed: MSS Rep E, I-08) AMA-MSS Digest of Policy Actions/ 67 (Reaffirmed: GC Rep B, I-13)

305.058MSS AMA-MSS Medical Student Loan & Financial Aid Online Education Resource:
(1) AMA-MSS will ask the AMA to reaffirm AMA Policies H-305.989 and H-305.996. (2) AMA-MSS will request that each medical school provide to the MSS its own up to date online resource explaining prior to enrollment its loan disbursement procedures and any private loans the school may offer. (MSS Sub Res 1, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

305.073MSS Transparency in Medical Student Financial Aid Reporting:
AMA-MSS will ask the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine to require greater transparency in financial aid information provided to medical students and applicants by encouraging medical colleges to provide additional data to students and applicants including but not limited to: (1) average debt incurred in medical school for graduating students with federal aid assistance, separated by in-state and out-of-state students, reported in quartiles (2) percent of current students receiving financial aid other than loans, and (3) the amount and types of available non-loan aid such as scholarships, interest-free loans, or grants available from the institution. (MSS Res 1, A-12)

275.012MSS Support A Study on the Minimum Competencies and Scope of Medical Scribe Utilization:
AMA-MSS will ask that our AMA 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 Res 28, A-16)

295.011MSS Regulation of Medical Student Education Opportunities:
AMA-MSS will ask the AMA to publicly reaffirm its support for the LCME standard for accreditation of undergraduate medical education programs and to oppose legislation or other efforts by state or federal regulatory agencies to define standards which limit educational opportunities in the training process of future physicians. (AMA Res 142, I-87 Adopted [H-295.974]) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)

305.080MSS Novel Mechanism to Reduce Medical Student Debt:
AMA-MSS will ask the AMA to study the feasibility and effectiveness/utility of loan forgiveness programs for the private sector including but not limited to the offering of tax credits and/or benefits to employers who pay the remaining balance of medical school loans when hiring
(MSS Res 6, A-15) (AMA Res 908, I-15 Reaffirmation Calendar)

(MSS Res 11, A-12) Cost Transparency through Clinical Report Documentation:
The MSS formally establishes support for the following HOD policy: AMA-MSS Digest of Policy Actions/157 H-185.975 Requiring Third Party Reimbursement Methodology be Published for Physicians 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 pursuant to the terms of the contract, the contract may not be used by any other payer.
Whereas, Florida State Statute §316.2398 states that a physician may while responding to an emergency in the line of duty, display or use red warning signals visible from the front and from the rear of such vehicle, subject to specific restrictions and conditions and it is unlawful for a physician to operate such warning signals except when responding to an emergency in the line of duty;¹ and

Whereas, Michigan State Vehicle Code 257.698 states that a private motor vehicle of a physician responding to an emergency call may be equipped with and the physician may use flashing, rotating, or oscillating red lights mounted on the roof section of the vehicle, provided that the physician has obtained written authorization from the county sheriff;² and

Whereas, California Vehicle Code 21058 states that a physician traveling in response to an emergency call shall be exempt from the California Vehicle Code sections regarding speed limits provided they an insignie approved by the department indicating that the vehicle is owned by a licensed physician and that this does not relieve the driver of the vehicle from the duty to drive with due regard for the safety of all persons using the highway, nor protect the driver from the consequences of an arbitrary exercise of the privileges³; and

Whereas, The California Medical Association collaborated with the California Highway Patrol to to implement California Vehicle Code 21058 and allowed member physicians to order “Emergency Situation Driving Emblems” at no extra cost⁴; and

Whereas, A definition of “medical emergency” according to Medicaid is “a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person’s health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy”\(^5\); and

Whereas, There is no available data or research on the safety or efficacy of the utilization of emergency lights by physicians in their private vehicles as they respond to medical emergencies; and

Whereas, The use of emergency lights by EMS personnel has been shown to decrease response time but there is debate within the literature regarding if there is a an association between improved response time and patient outcomes\(^6,7,8,9,10\); and be it further

RESOLVED, That our AMA encourage research on the effect of physician use of emergency lights in privates vehicles when responding to medical emergencies, which should include effects on response time, patient outcomes and physician motor vehicle safety.


\(^6\) Ho, Jeffrey, and Mark Lindquist. "Time saved with the use of emergency warning lights and siren while responding to requests for emergency medical aid in a rural environment." Prehospital Emergency Care 5.2 (2001): 159-162.


RELEVANT AMA AND AMA-MSS POLICY

Mandatory Seat Belt Utilization Laws H-15.982

Our AMA (1) supports mandatory seat belt utilization laws which do not simultaneously relieve automobile manufacturers of their responsibility to install passive restraints; (2) favors informing state medical societies about the status of mandatory seat belt utilization laws which simultaneously relieve automobile manufacturers of their responsibility to install passive restraints; (3) urges reconsideration of the administrative regulation of the U.S. Department of Transportation that would release automobile manufacturers from the responsibility of providing passive restraints when mandatory seat belt utilization for two-thirds of the U.S. population is attained; and (4) supports the amendment of state seat belt laws which contain exemptions for emergency medical services personnel, such that these laws would provide exemptions only when personnel are actively involved in patient care.

Bolstering Public Health Preparedness H-440.892

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

Legal Issues Surrounding the Deployment and Utilization of Licensed Physicians in Response to Declared Disasters H-130.941

Our AMA: (1) encourages physicians who are interested in volunteering during a disaster to register with their state's Emergency System for Advance Registration of Volunteer Health Professionals program, local Medical Reserve Corps unit, or similar registration systems capable of verifying that practitioners are licensed and in good standing at the time of deployment; and (2) (a) supports the National Conference of Commissioners on Uniform State Laws (NCCUSL) Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) with the liability language of Alternative A; and (b) continues to advocate for civil liability protections for qualified physicians that provide care in a disaster who are not covered under the UEVHPA, but are covered in AMA model legislation titled "To Protect Physicians from Civil Liability Arising from Health Care Provided During a Disaster."

Seat Belt Compliance in Emergency Vehicle Patient Compartments 15.010MSS

AMA-MSS will ask the AMA to collaborate with national emergency medicine and emergency medical services organizations to develop educational resources and training for employees regarding seat belt usage in the patient compartments of emergency vehicles; and (2) support the amendment of state seat belt laws with blanket exemptions for emergency medical services personnel such that these laws provide exemptions only when actively involved in patient care.
Whereas, Data science is an approach to statistical analysis that utilizes information technology, computer science, and artificial intelligence;¹⁻² and

Whereas, Machine intelligence, a subset of artificial intelligence, is an approach to data science that refers to the implementation of techniques, such as machine learning and natural language processing, used to improve predictive analyses;³⁻⁶ and

Whereas, Machine intelligence is rapidly being used as a routine part of clinical care, particularly in the fields of cardiology, radiology, and surgery;⁶⁻¹⁴ and

References:

Whereas, Experts have raised significant ethical and procedural concerns regarding proper implementation of machine intelligence in healthcare settings, particularly the introduction of a third party into the physician-patient relationship and the codification of existing biases;\textsuperscript{14-18} and

Whereas, Data science literacy is necessary for effective implementation of machine intelligence in the healthcare setting, including critical interpretation of conclusions and competent analysis of literature that rely on this technology;\textsuperscript{18-22} and

Whereas, Few medical programs provide robust data science education;\textsuperscript{23-25} and

Whereas, Industry leaders have identified a critical need to implement data science education in medical schools and hospitals;\textsuperscript{26-29} and

Whereas, The rise of advanced data science in healthcare, in particular machine intelligence, highlights the need for standardized, core competency guidelines for physician data science literacy;\textsuperscript{30} be it further

RESOLVED, That our AMA-MSS promote physician data science literacy.


\textsuperscript{24} LCME Annual Medical School Questionnaire. Data from 2010-2011 through 2013-2014. Number of Medical Schools Including Topic in Required Courses and Elective Courses: Biomedical Informatics. Retrieved from https://www.aamc.org/initiatives/cir/406462/06a.html.


\textsuperscript{27} Lucey, C. R. (2013). Medical education: part of the problem and part of the solution. JAMA Internal Medicine, 173(17), 1639–1643.


\textsuperscript{29} Huesch M. D., & Mosher T. J. (2017). Using it or losing it? The case for data scientists inside Health Care. NEJM Catalyst.

RESOLVED, That our AMA-MSS advocate for the development of core physician data science competency guidelines.

RESOLVED, That our AMA-MSS encourage medical schools to explore the implementation of more robust data science education.

Fiscal Note: Moderate, 7

Date Received: 04/11/2018

RELEVANT AMA AND AMA-MSS POLICY

Clinical Algorithm Impact on Patient Care H-410.971
The AMA has established the following policy that incorporates provisions regarding the use and development of clinical algorithms, which may include the following: (1) Clinical algorithms are guidelines established to aid a physician in the diagnosis and treatment of patients. As such, they should be used by the physicians as guidelines, but recognizing that each patient is an individual and has unique needs and problems, the physician should use his or her best judgment in the use of the guidelines and should never be forced to specifically follow these guidelines rigidly. (2) Clinical algorithms should include suggested tests and procedures to arrive at a correct diagnosis in the most direct and expeditious manner. These guidelines should suggest criteria as to when referrals to the correct specialist/subspecialist are appropriate and in the best interest of the patient. (3) The treating physicians should always have the option of ordering the suggested tests, procedures and referrals at their discretion, and may opt to make these choices earlier or later than is suggested, and is not mandated to make any of these choices, depending on their clinical assessment of the patient and their needs. (4) When the algorithms are created, physicians from the specialty(ies)/subspecialty(ies) who diagnose and treat the condition should participate in their creation. These physicians should be representatives from their official specialty society(ies). (5) The validity of any clinical algorithms should be under constant review and evaluation by the appropriate specialty/subspecialty society(ies). (6) Whenever possible consensus clinical data from peer review journals will be used.

National Agency for Technology Evaluations H-480.954
Our AMA advocates for active AMA input into any national agency whose role would be to evaluate technology for its value, to assist Medicare and other payers in making appropriate coverage decisions.

Technology and the Practice of Medicine G-615.035
Our AMA encourages the collaboration of existing AMA Councils and working groups on matters of new and developing technology, particularly electronic medical records (EMR) and telemedicine.
Modernization of Medical Education Assessment and Medical School Accreditation: AMA-MSS will ask the AMA to: (1) vigorously work to establish medical education system reforms throughout the medical education continuum that demand evidence-based teaching methods that positively impact patient safety or quality of patient care; and (2) work with the Liaison Committee on Medical Education (LCME) to perform frequent and extensive educational outcomes assessment of specialized competencies in the medical school accreditation process at minimum every four years, requiring evidence showing the degree to which educational objectives impacting patient safety or quality of patient care are or are not being attained. (MSS Res 9, A-04) (AMA Res 818, I-04 Referred) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

Medical Technology Assessment 480.001MSS
AMA-MSS supports the following principles: (1) Medical technology assessment should include societal, economic, ethical, and legal consequences of medical technologies, as well as concerns of safety and efficacy. (2) The medical community should stress the use of randomized, controlled clinical trials when ethical prior to the wide spread dissemination of medical technologies and emphasize the importance of clinical trials to health professionals. (3) Medical technologies should not be accepted as standard medical practice before they have been adequately assessed with respect to their safety, efficacy, cost-effectiveness and societal consequences. (4) Organized medicine should continue its involvement with the Prospective Payment Assessment Commission, and should actively lobby for funding which would allow this body to accomplish its mandate with regard to medical technology evaluation. (5) Organized medicine should support the creation of a private/public sector consortium, as defined by the Institute of Medicine of the National Academy of Sciences, which would act as a clearinghouse for the evaluation of medical technologies. (6) Organized medicine should seek active representation in such a private/public sector consortium, and should research possible sources of funding (e.g., government, third party payers, technology producers). (7) Organized medicine should work to assure a mechanism for awarding competitive grants to fund high quality clinical trials for the assessment of medical technology.

Machine Intelligence in Healthcare 485.003MSS
AMA-MSS (1) supports the use of machine intelligence as a complementary tool in making clinical decisions; (2) supports ethical, rapid development and deployment of machine intelligence research and machine learning techniques to improve clinical decision making, including diagnosis, patient care, and health systems management; (3) supports partnerships with organizations actively developing machine intelligence and other appropriate groups to evaluate clinical outcomes, develop regulatory guidelines for the use of machine intelligence in healthcare, and ensure further developments will be beneficial to patients, physicians, and society; (4) encourages the education of medical students and physicians on the use of machine intelligence in healthcare; and (5) supports increased utilization of the term "machine intelligence" rather than the term "artificial intelligence" when considering the use of computers to parse data, learn from it, and develop clinical guidelines or facilitate clinical decision-making.
AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 37
(A-18)

Introduced by: Region 2, Region 5, Tabitha Moses, Lara Fahmy, Aileen Haque, Lauren Newhouse, Deepthi Shanbhag; Wayne State University School of Medicine; Lauren Engel, Medical College of Wisconsin; Shiri Nawrocki, Rutgers-Robert Wood Johnson Medical School; Julie Lin, Northeast Ohio Medical University

Subject: Opposition to Lack of Evidence Based Medicine in Drug Courts

Referred to: MSS Reference Committee
(Celeste Peay, Chair)

Whereas, A Substance Use Disorder (SUD) is a medical illness characterized by clinically significant impairments in health, social function, and voluntary control over substance abuse, and SUD costs more than $600 billion annually in criminal activity, healthcare costs, and lost productivity,\(^1,2\) and

Whereas, In 2015, 66.7 million people in the United States reported past-month binge drinking and 27.1 million people were currently using illicit drugs or misusing prescription drugs, and in 2009 the prevalence of SUD was suggested to be as high as 50% in prisoners;\(^3,4\) and,

Whereas, Drug courts were created as a way to relieve trial courts of the overwhelming volume of drug-related cases and integrate substance abuse treatment with the pretrial processing of a criminal case, and to allow individuals whose crimes stem from addiction to receive treatment instead of jail time;\(^5\) and

Whereas, Drug courts (of which there are more than 3,100 operating in 50 states) rely on collaborations between the justice system, treatment agencies (or providers), community organizations, and other representatives, and while each operates differently, all share the understandings that drug addiction is a treatable chronic disease, and that targeting individuals in the post-arrest period can break the drug-crime cycle;\(^6,7\) and

Whereas, The most effective treatment method for long-term results for opioid use disorder is completion of medically supervised withdrawal followed by medication-assisted therapy (MAT) augmented by psychosocial treatment, and recommended psychosocial treatments include

\(^3\) Center for Behavioral Health Statistics and Quality, “Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Health (HHS Publication No. SMA 16-4984, NSDUH Series H-51),” 2016, http://www.samhsa.gov/data
addiction counseling, mutual help groups, motivational interviewing, behavioral therapies, contingency management, and twelve-step facilitation programs, and

Whereas, An addiction medicine certification allows a specialist, other than a psychiatrist, to provide prevention, screening, intervention, and treatment for substance abuse and addiction, including the psychiatric and physical complications of addiction for a patient, and these physicians are certified by the American Board of Preventive Medicine (ABPM), the American Board of Addiction Medicine (ABAM), or the American Osteopathic Association (AOA), and

Whereas, In 2011, the National Association of Drug Court Professionals (NADCP) Board of Directors issued a resolution directing drug courts to follow a set of standards while issuing treatment plans to the convicted and that they must keep an open mind and learn the facts about MAT and obtain expert medical consultation on MAT when available, and,

Whereas, The 2011 NADCP standards state that drug courts must also make a fact-sensitive inquiry in each case to determine whether MAT is medically indicated or medically necessary for the participant and to explain the court’s rationale for permitting or disallowing use of MAT; and

Whereas, Treatments are offered at the judge’s discretion and vary from court to court, and while some courts offer a full range of evidence-based treatments, some prohibit medication-based treatments, and others permit only Vivitrol™ (naltrexone extended-release injection), and

Whereas, Pharmaceutical companies advertise products to drug court judges via educational materials and sales representatives, and are considered part of the extended drug court team and thus involved in the day-to-day operations of the program; this may be a conflict of interest, as evidenced by the rise in naltrexone prescribing in drug courts, which may be attributable to targeting lobbying and marketing efforts by the manufacturer of Vivitrol™, and

Whereas, While extensive research shows that each of the three available medications used to treat opiate addiction have superior outcomes to non-medication based therapies, there is no scientific evidence to favor the use of naltrexone over buprenorphine or methadone, therefore be it

RESOLVED, That our AMA oppose court-mandated, specific treatment requirements for defendants without appropriate physician guidance; and be it further,

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RESOLVED, That our AMA support the physician's role within drug courts for developing specific pharmacological treatment for patients with substance abuse disorder; and be it further, RESOLVED, That our AMA recommend the creation of guidelines for the judge-pharmaceutical company relationship that are aligned with current physician guidelines.

Fiscal Note: Significant, 10

Date Received: 4/11/2018

RELEVANT AMA POLICY:

Support for Drug Courts H-100.955
Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; and (2) encourages legislators to establish drug courts at the state and local level in the United States.

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.

Recognition of Those Who Practice Addiction Medicine H-300.962
1. It is the policy of the AMA to: (a) encourage all physicians, particularly those in primary care fields, to undertake education in treatment of substance abuse; (b) direct its representatives to appropriate Residency Review Committees (RRCs) to ask the committees on which they serve to consider requiring instruction in the recognition and management of substance abuse. Those RRCs that already require such instruction should consider greater emphasis for this subject. (c) encourage treatment of substance abuse as a subject for continuing medical education; and (d) affirm that many physicians in fields other than psychiatry have graduate education and experience appropriate for the treatment of substance abuse, and for utilization review, and for other evaluation of such treatment, and should be entitled to compensation.

2. Our AMA commends 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.

3. Our AMA encourages the ABPM to offer the first ABMS-approved certification examination in addiction medicine expeditiously in order to improve access to care to treat addiction.

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.

**Drug Abuse in the United States - Treatment Effectiveness And Capacity - A Preliminary Report H-95.969**

Given the need throughout the health care delivery field for more effective and efficient forms of treatment, it is important to investigate the potential for better patient-treatment matching in treating alcohol and drug abusers. Researchers usually try to isolate each element of treatment in order to study it scientifically. In practice, however, several treatment approaches are typically used simultaneously or sequentially. In general, there have been too few well-controlled studies of combined interventions to permit final conclusions about their overall effectiveness in alcohol and drug abuse patients. The available findings are somewhat unimpressive, however, given the scope and intensity of the many combined treatment programs. One reason for the lack of impressive findings may have to do with patient characteristics which determine the amount of change which will occur with any treatment, and perhaps the degree to which additional treatment will result in additional measurable change. In highly motivated good-prognosis patients, for example, one well-chosen intervention - or even standard treatment - may produce maximal amounts of change, making the impact of additional interventions unmeasurable and, by implication, unnecessary. In poor-prognosis patients, on the other hand, the overall amount of change possible may be very limited, making a significant difference between one or many interventions difficult to demonstrate. Finding patient variables (i.e., prior drinking pattern, psychiatric morbidity) that are strongly predictive of treatment outcome may help identify patients expected to benefit least - and most - from multiple interventions. The AMA believes immediate attention should be given to all of these areas of urgently needed action, and commits itself to continued participation in the formulation, dissemination, and evaluation of the national responses to the problems of alcohol and drug abuse.

**9.7.2 Court-Initiated Medical Treatment in Criminal Cases**

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.

9.6.2 Gifts to Physicians from Industry
Relationships among physicians and professional medical organizations and pharmaceutical, biotechnology, and medical device companies help drive innovation in patient care and contribute to the economic well-being of the community to the ultimate benefit of patients and the public. However, an increasingly urgent challenge for both medicine and industry is to devise ways to preserve strong, productive collaborations at the same time that they take clear effective action to prevent relationships that damage public trust and tarnish the reputation of both parties.

Gifts to physicians from industry create conditions that carry the risk of subtly biasing—or being perceived to bias—professional judgment in the care of patients.

To preserve the trust that is fundamental to the patient-physician relationship and public confidence in the profession, physicians should:
(a) Decline cash gifts in any amount from an entity that has a direct interest in physicians’ treatment recommendations.
(b) Decline any gifts for which reciprocity is expected or implied.
(c) Accept an in-kind gift for the physician’s practice only when the gift:
   (i) will directly benefit patients, including patient education; and
   (ii) is of minimal value.
(d) Academic institutions and residency and fellowship programs may accept special funding on behalf of trainees to support medical students’, residents’, and fellows’ participation in professional meetings, including educational meetings, provided:
   (i) the program identifies recipients based on independent institutional criteria; and
   (ii) funds are distributed to recipients without specific attribution to sponsors.

9.6.7 Direct-to-Consumer Advertisement of Prescription Drugs
Direct-to-consumer advertising may raise awareness about diseases and treatment and may help inform patients about the availability of new diagnostic tests, drugs, treatments, and devices. However, direct-to-consumer advertising also carries the risk of creating unrealistic expectations for patients and conflicts of interest for physicians, adversely affecting patients’ health and safety, and compromising patient physician relationships.

In the context of direct-to-consumer advertising of prescription drugs, physicians individually should:
(a) Remain objective about advertised tests, drugs, treatments, and devices, avoiding bias for or against advertised products.
(b) Engage in dialogue with patients who request tests, drugs, treatments, or devices they have seen advertised to:
   (i) assess and enhance the patient’s understanding of the test, drug or device;
   (ii) educate patients about why an advertised test, drug, or device may not be suitable for them, including providing cost-effectiveness information about different options.
(c) Resist commercially induced pressure to prescribe tests, drugs, or devices that may not be indicated.
(d) Obtain informed consent before prescribing an advertised test, drug, or device, in keeping with professional standards.
(e) Deny requests for an inappropriate test, drug, or device.
(f) Consider reporting to the sponsoring manufacturer or appropriate authorities direct-to-consumer advertising that:
(i) promotes false expectations;
(ii) does not enhance consumer education;
(iii) conveys unclear, inaccurate, or misleading health education messages;
(iv) fails to refer patients to their physicians for additional information;
(v) does not identify the target population at risk;
(vi) encourages consumer self-diagnosis and treatment.
Collectively, physicians should:
(g) Encourage and engage in studies that examine the impact of direct-to-consumer advertising on patient health and medical care.
(h) Whenever possible, assist authorities to enforce existing law by reporting advertisements that do not:
(i) provide a fair and balanced discussion of the use of the drug product for the disease, disorder, or condition;
(ii) clearly explain warnings, precautions, and potential adverse reactions associated with the drug product;
(iii) present summary information in language that can be understood by the consumer
(iv) comply with applicable regulations;
(v) provide collateral materials to educate both physicians and consumers.
Whereas, On February 26, 2014, the ACGME, American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM) announced their agreement to a Memorandum of Understanding, outlining a single graduate medical education accreditation system in the United States; and

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

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

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

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

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

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

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

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

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

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

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

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

RESOLVED, That our AMA ensure equal acceptance of the USMLE and COMLEX at all United States residency programs;

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

RESOLVED, That the AMA work with Residency Program Directors to ensure higher COMLEX utilization with residency program matches in light of the new single accreditation system.
References:


81. Colorado School of Public Health Occupational and Environmental Residency Admissions.


RELEVANT AMA AND AMA-MSS POLICY:

ACGME Residency Program Entry Requirements H-310.909
Our AMA supports entry into Accreditation Council on Graduate Medical Education (ACGME) accredited residency and fellowship programs from either ACGME-accredited programs or American Osteopathic Association-accredited programs. Res 920, I-12

Potential Impact of the USMLE Step 2 CS and COMLEX-PE on Undergraduate and Graduate Medical Education D-275.981
Our AMA will: (1) continue to closely monitor the USMLE Step 2 CS and the COMLEX-USA Level 2-PE, collecting data on initial and final pass rates, delays in students starting residency training due to scheduling of examinations, economic impact on students, and the potential impact of ethnicity on passing rates; and (2) encourage residency program directors to proactively evaluate their access to resources needed to assist resident physicians who have not passed these examinations to remediate. CME Rep. 4, A-04; Modified: CME Rep. 2, A-14

H-275.934 - Alternatives to the Federation of State Medical Boards Recommendations on Licensure
Our AMA adopts the following principles: (1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be
certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants. CME Rep. 8, A-99; Reaffirmed: CME Rep. 4, I-01; Reaffirmed: CME Rep. 2, A-11; Modified: CME Rep. 2, A-12

**D-295.939 - Independent Regulation of Physician Licensing Exams**
Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system in support of Policy H-295.893, "Voting Rights for AMA-MSS NBME Representatives;" (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). CME Rep. 10, A-08

**D-295.988 - Clinical Skills Assessment During Medical School**
1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.
2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing
this examination within our nation's medical schools, rather than administered by an external
organization; and (e) include active participation by faculty leaders and assessment experts
from U.S. medical schools, as they work to develop new and improved methods of assessing
medical student competence for advancement into residency.
4. Our AMA is committed to assuring that all medical school graduates entering graduate
medical education programs have demonstrated competence in clinical skills.
5. Our AMA will continue to work with appropriate stakeholders to assure the processes for
assessing clinical skills are evidence-based and most efficiently use the time and financial
resources of those being assessed.
6. Our AMA encourages development of a post-examination feedback system for all USMLE
test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas
of suboptimal performance; and (c) give students who fail the exam insight into the areas of
unsatisfactory performance on the examination.
7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data
and engage with stakeholders as necessary should updates to this policy become necessary.
CME Rep. 09, A-17

H-310.919 - Eliminating Questions Regarding Marital Status, Dependents, Plans for
Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and
Religion During the Residency and Fellowship Application Process
Our AMA will:
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic
Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in
the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider
the effects these changes may have on efforts to increase diversity in residency programs.

275.011MSS - Transfer of Jurisdiction Over Required Clinical Skills Examination to
LCME-Accredited and COCA-Accredited Medical Schools
The AMA-MSS will (1) ask our AMA, working with the state medical societies, to 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; (2) ask
the AMA to amend D-295.998 by insertion and deletion 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 institutions pass a school administered clinical skills
examination to graduate from medical school.; and (3) ask 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 Res 01, A-16 Immediate Transmittal) (AMA Res
321, A-16 Alternate Resolution 311, A-16 Adopted as Amended in Lieu of Res 311, 316, 317,
and 321
295.114MSS - Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam Physical Exam Implementation

(1) AMA-MSS will ask the AMA to: (a) study mechanisms for providing feedback to medical students on their performance on the proposed United States Medical Licensing Exam (USMLE) Clinical Skills Assessment Examination (CSAE) and College of Osteopathic Medicine Licensing Exam-Physical Exam (COMLEX-PE) including but not limited to written narrative feedback, and access to video recording of the exam for possible review with their medical school and communicate these findings to the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME); (b) encourage medical schools to develop mechanisms to assist medical students to meet financial obligations associated with the requirements for participation in the CSAE and COMLEX-PE; (c) encourage medical schools to avoid linking passage of the CSAE and COMLEX-PE to graduation requirements for at least the first 5 years of the implementation of the exam; (d) encourage medical schools to reevaluate their educational programs to ensure appropriate emphasis of clinical skills training in medical schools; (e) study, in conjunction with the NRMP, AOA, AGCME, and other interested organizations, the potential impact of the CSAE and COMLEX-PE on undergraduate and graduate medical education; (f) strongly encourage the NBME and NBOME to develop policies to ensure adequate capacity for registration and administration of the CSAE and COMLEX-PE in order to accommodate all students testing for the initial time as well ensuring students failing the exam can retest within 4 months; and (g) monitor in an ongoing fashion, the implementation of the CSAE and COMLEX-PE and its impact on the medical education continuum. (2) AMA-MSS will study safeguard measures for students in the first five years of implementation of the Clinical Skills Assessment Exam and COMLEX-PE; MSS Res 7, A-03; AMA Amended Res 324, A-03 Adopted in Lieu of Resolution 315 [D-275.985]; Amended: MSS Rep E, I-08; D-275.985 Rescinded: CME Rep. 2, A-13; Reaffirmed: GC Rep B, I-13

295.150MSS - USMLE Exam Fee Burden

AMA-MSS will study the actual costs of producing and administering the USMLE and COMLEX computer-based and clinical skills exams to determine the fairness and inherent burden of examination fees imposed on medical students. MSS Res 4, A-10; Reaffirmed, MSS GC Rep D, I-15
Whereas, 2014 Juvenile Residential Facility Census data reported only 58% of juvenile
detention facilities regularly screened youth for mental health needs;¹ and

Whereas, Our AMA supports surveying the availability of mental health services availability in
juvenile detention centers; and

Whereas, According to the National Commission on Correctional Health Care, a reduction in
federal funding significantly contributes to inadequate health care for detained youth;² and

Whereas, On August 1, 2017, the U.S Senate reauthorized the Juvenile Justice and
Delinquency Prevention Act of 1974 to promote the use of alternatives to incarceration,
implement trauma-informed and evidence-based practices, improve conditions, and increase
accountability within the Juvenile Detention system;³ and

Whereas, A study identifying barriers to mental health treatment continuity demonstrated that
individuals diagnosed with a mental health disorder prior to entering prison, tend to not receive
treatment while incarcerated;⁴ and

Whereas, In the juvenile justice system minority youth experience tougher punishments and
more negative outcomes than White youth;⁵ and

Whereas, A longitudinal study of detained youth identified that a negative perception of the
correctional climate and a history of mental illness had the greatest correlation with mental
health symptoms in young prisoners;⁶ and

Whereas, Black youth account for only 16 percent of the general population. However, The
National Council on Crime and Delinquency revealed that Black and Latino youth have the top
rates of detention;⁷ and

² Health Care Funding for Incarcerated Youth, National Commission on Correctional Health Care. (2014). www.ncchc.org/health-
care-funding-for-incarcerated-youth.
Information Exchange. jjie.org/2017/08/02/advocates-focus-on-conference-committee-after-jjdpa-reauthorization-bill-passes-senate/.
⁴ Reingle Gonzalez, J. M., & Connell, N. M. (2014). Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and
⁵ Campbell, N. A., Barnes, A. R., Mandalari, A., Onifade, E., Campbell, C. A., Anderson, V. R., ..., Davidson, W. S.
(2017). Disproportionate minority contact in the juvenile justice system: An investigation of ethnic disparity in program referral at
young prisoners: exploring the influence of personal factors and the correctional climate. BMC Psychiatry, 16, 91.
Whereas, Minority youth with mental health diagnoses are less likely to receive referral for mental health care than white youth with similar diagnoses; and therefore be it

Resolved, That Our AMA-MSS will support equal and appropriate mental health referrals in the detained minority youth population; and be it further

Resolved, That Our AMA-MSS will advocate for mandatory and nondiscriminatory mental health screenings for all juvenile delinquents prior to admission, and continued mental health care throughout periods of detainment and after release; and be it further

Resolved, That Our AMA-MSS support focused funding on research and regular evaluations to decrease disparities in mental health screening protocols at juvenile detention centers.

Fiscal Note: Minimal, 6

Date Received: 04/11/18

RELEVANT AMA AND AMA-MSS POLICY

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)

Reduced Incarceration and Improved Treatment of Individuals with Mental Illness or Illicit Drug Dependence 345.006MSS

AMA-MSS will ask the AMA to amend policy H-430.989 by insertion and deletion as follows: H-430.989 Disease Prevention and Health Promotion in Correctional Institutions. 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 1. the prevention and control of HIV/AIDS, substance abuse, tuberculosis and hepatitis, 2. the management and treatment of psychiatric disorders such as drug dependence, and 3. a reduction in reincarceration rates related to drug abuse and psychiatric disorders. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers, and drug treatment center staff, and psychiatric care 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 history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs, as well as inpatient or outpatient psychiatric treatment programs, as a sentence or in connection with sentencing." (MSS Res 30, I-11) (HOD Policy H-430.997 Amended in Lieu of AMA Res 502, A-12) (Reaffirmed: MSS GC Report A, I-16)

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Health Care While Incarcerated H-430.986

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.

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.

Juvenile Justice System Reform H-60.919

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.

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.

Health Status of Detained and Incarcerated Youth H-60.986

Our AMA 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.

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

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

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

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

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

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

RESOLVED, that our AMA encourage news media organizations to guide their coverage of mass shootings by the principles laid out in the Recommendations for Reporting on Suicide while more specific guidelines regarding coverage of mass shootings are developed; and be it further

RESOLVED, that our AMA encourage the Center for Disease Control, the National Institute of Mental Health, the Associated Press Managing Editors, the National Press Photographers Association, and other relevant organizations to develop guidelines for media coverage of mass shootings in a manner that is unlikely to provoke additional incidents.

Fiscal note: Significant, 12

Date received: 04/11/18

RELEVANT AMA AND AMA-MSS POLICY:

Mass Media Violence and Film Ratings H-515.974
Redressing Shortcomings in the Current System: The AMA: (1) will speak out against the excessive portrayal of violence in the news and entertainment media, including newscasts, movies, videos, computer games, music and print outlets, and encourage the depiction of the medical, social and legal consequences of violence by the media; (2) advises physicians to counsel parents about the known effects of media violence on children’s behavior and encouraging them to reduce the amount of violent programming viewed by their children; (3) monitors changes in the current ratings system and working through state medical societies to inform physicians and their patients about these changes; and (4) supports all other appropriate measures to address and reduce television, cable television, and motion picture violence.


Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA:
(1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns;
(5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

Gun Violence as a Public Health Crisis D-145.995
Our AMA:
(1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and
(2) will actively lobby Congress to lift the gun violence research ban.

Physicians and the Public Health Issues of Gun Safety D-145.997
Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

Epidemiology of Firearm Injuries D-145.999
Our AMA will:
(1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and
(2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms.

Firearm Related Injury and Death: Adopt a Call to Action H-145.973
Our AMA endorses the specific recommendations made by an interdisciplinary, interprofessional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American 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.
Whereas, Across industrialized nations, the United States has one of the highest maternal mortality rates and rates continue to rise;¹ and

Whereas, A 2017 report from Maternal Mortality Review Committees within the CDC Foundation determined that 60% of these deaths were preventable;² and

Whereas, The American medical system devotes more time and resources to infant safety, resulting in insufficient awareness of potential complications that could arise in postpartum mothers;³ and

Whereas, Though black mothers are just as likely to experience postpartum complications as white mothers, the black maternal mortality rate is three times higher;⁴ and

Whereas, This difference is present despite increased patient education, as college-educated black women suffer from a greater rate of life-threatening complications during delivery, compared to white women who never graduated high school;⁵ and

Whereas, Due to chronic stress and the high effort of coping associated with living in a society that marginalizes black people, black women experience a higher degree of epigenetic modifications than white women;⁶ and

Whereas, These epigenetic modifications coincide with early health deterioration, putting black mothers at a greater risk for complications during and after pregnancy;\(^6,7\) and

Whereas, Peripartum and postpartum care for black women is further worsened by implicit bias in healthcare, evidenced by studies showing insufficient pain management in black women compared to white women, and lower efficacy of communication between physicians and black patients;\(^8,9,10,11\) and

Whereas, Black women who experience such racial discrimination during birth hospitalization “had more than twice the odds of postpartum visit nonattendance,” which is further exacerbated by culturally-derived mistrust in the healthcare system;\(^12,13\) and

Whereas, Due to the significant underreporting of maternal mortality in the United States and insufficient consideration of race-based reporting, a complete understanding of the high maternal mortality rate in black women has yet to be elucidated;\(^14\) and

Whereas, Council on Science and Public Health (CSAPH) Report 3-A-09, Disparities in Maternal Mortality, found that the Commission to End Health Care Disparities was the most appropriate body to work on disparities in maternal mortality, and recommended that the AMA work exclusively through the Commission to “evaluate the issue of health disparities in maternal

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\(^12\) Attanasio, L., & Kozhimannil, K. B. (2017). Health Care Engagement and Follow-up After Perceived Discrimination in Maternity Care. Medical Care, 55(9), 830-833. doi:10.1097/mca.0000000000000773


mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States”\(^{15}\) and

Whereas, The recommendation from CSAPH Report 3-A-09 was codified as AMA Policy D-420.993, which replaced previous policy and called for a direct AMA collaboration to raise awareness about and study racial disparities in maternal mortality; and

Whereas, While the Commission to End Health Care Disparities provided broad strategies to tackle racial disparities in a clinical setting, the Commission did not release any recommendations specific to ameliorating health disparities in maternal mortality, and therefore did not fulfill the request of CSAPH Report 3-A-09;\(^{16}\) and

Whereas, The Commission to End Health Care Disparities was retired in 2016, rendering the active party designated by AMA Policy D-420.993 no longer able to carry out its charge, leaving the AMA without an active party working on health disparities in maternal mortality; and

Whereas, The American Medical Association has recognized maternal mortality as an issue and supports the formation of review committees and surveillance systems (D-420.992, H-60.909, H-420.905, D245.994), but currently lacks effective policy recognizing and directing action on maternal mortality in black women and the contribution of implicit biases to maternal outcomes; therefore be it

RESOLVED, That our American Medical Association encourage education about higher rates of postpartum complications in black mothers and awareness of the need for increased clinical attention to postpartum black women whose maternal care is affected by implicit biases; and be it further

RESOLVED, That our American Medical Association work with the American College of Obstetricians & Gynecologists to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States.


Fiscal note: Significant, 11

Date received: 4/11/2018

RELEVANT AMA AND AMA-MSS POLICY:

Disparities in Maternal Mortality D-420.993
Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; and (3) encourages and promotes to all state and county health departments to develop a maternal mortality surveillance system.

State Maternal Mortality Review Committees H-60.909
Our AMA supports: (1) the important work of maternal mortality review committees; (2) work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees; and (3) work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees.

Medical Care for Indigent and Culturally Displaced Obstetrical Patients and their Newborns H420.995
Our AMA (1) reaffirms its long-standing position regarding the major importance of high-quality obstetrical and newborn care by qualified obstetricians, family physicians, and pediatricians and the need to make such care available to all women and newborns in the United States; (2) favors educating the public to the long-term benefit of antepartum care and hospital birth, as well as the hazards of inadequate care; and (3) favors continuing discussion of means for improving maternal and child health services for the medically indigent and the culturally displaced.

Infant Mortality D-245.994
1. Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers.

2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevalence of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative
effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives.

Racial and Ethnic Disparities in Health Care H-350.974

1. 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.

2. The AMA emphasizes three approaches that it believes should be given high priority:
A. 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.
B. 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.
C. 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.

3. 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.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
Resolution 42

(A-18)

Introduced by: Region 5; Liz Martin, Katie George, Jaya Parulekar, and Hannah Kopinsky, Wayne State University School of Medicine; Alexandria Wellman, Southern Illinois University School of Medicine; Neha Anand, Johns Hopkins University School of Medicine; Sarah Puryear, Case Western Reserve University School of Medicine

Subject: Increasing Firearm Safety to Prevent Accidental Child Deaths

Referred to: MSS Reference Committee (Celeste Peay, Chair)

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

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

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

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

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

7 Whereas, The American Academy of Pediatrics (AAP) recommends that pediatricians include

questions about the presence and availability of firearms in their patient history and urge
parents owning firearms to take action to prevent children from gaining access to those
firearms;\(^7\) and

Whereas, AMA Policy H-145.990 encourages physicians to educate patients on the dangers of
firearms to children, but H-145.990 does not address the issue of disparities in reporting
firearms between adults in households;\(^6\) and

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

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

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

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

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

Whereas, Research spending on firearm injuries conducting by the CDC fell by 96% from 1996
to 2012;\(^12\) and

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

Whereas, Existing AMA policy H-145.979 supports legislation that holds firearm owners legally

D6, Available at: http://pediatrics.aappublications.org/content/130/5/e1416.long#ref-30

\(^8\) Prevention of Firearm Accidents in Children H-145.990. (2013). American Medical Association. Available at:

594. Print.


http://lawcenter.giffords.org/design-safety-standards-for-handguns-in-california/

177(1):124–126. doi:10.1001/jamainternmed.2016.7076 Available at:
https://jamanetwork.com/journals/jama/article-abstract/258298?redirect=true

doi:10.1001/jama.2016.16215 Available at:
https://jamanetwork.com/journals/jama/article-abstract/2595514
responsible for injury or death caused by a child gaining access to a firearm;¹⁴ and

Whereas, Child Access Prevention (CAP) Laws, which encourage firearm owners to be conscious of how they store their firearms, may be more preventive than AMA policy H-145.979 because they range from strict laws that hold gun owners criminally liable when a child could likely gain access to their gun to more lenient forms that only hold gun owners criminally liable if a child actually obtains or uses the gun;¹⁵ and

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

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

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

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

RESOLVED, That our American Medical Association (AMA) amend existing policy, Prevention of Firearm Accidents in Children H-145.990, by addition (underlined type) as follows:

a. (c) encourage patients to educate their children and neighbors as to the dangers of firearms and have an open conversation with other caregiver(s) about firearm storage in the household; and be it further

RESOLVED, That our AMA advocate for increased funding for research on the benefits of firearm safety features such as loading indicators and magazine disconnects; and be it further

RESOLVED, That our AMA advocate for expansion of Child Access Prevention (CAP) Laws to all 50 states or to a federal law.

Fiscal Note: Significant, 12

Date Received: 04/11/18

Relevant AMA Policy

H-145.979 Prevention of Unintentional Shooting Deaths Among Children
Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.

H-145.990 Prevention of Firearm Accidents in Children
Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; (2) encourages state medical societies to work with other organizations to increase public education about firearm safety; and (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children.
WHEREAS, Existing AMA policies and recent publications have called attention to the need for topics of healthcare finance and medical economics to be featured in medical education curricula in order to equip future physicians with the knowledge to practice medicine in today’s ever-changing healthcare environment;¹,² and

WHEREAS, Recent empiric and anecdotal evidence indicates that physicians and residents still rate their knowledge of healthcare finance and medical economics as fair or low,³,⁴,⁵ and it is widely acknowledged that new physicians are not well-prepared to understand topics such as physician reimbursement, compensation and practice models;⁶,⁷ and

WHEREAS, There has been little to no study on whether or how schools have been incorporating these topics and/or how effective these changes have been; and

WHEREAS, The Association of American Medical Colleges (AAMC) Graduation Questionnaire from 2002 to 2013 repeatedly found that nearly two-thirds of medical students believed “medical economics” to have been inadequately addressed in their medical education,⁸ before the question was discontinued; and

WHEREAS, The Liaison Committee on Medical Education (LCME) outlines that “medical curriculum provides content of sufficient breadth and depth to prepare medical students for entry into any residency program and for the subsequent contemporary practice of medicine,” but neither directly advocates for the inclusion of topics like healthcare finance or medical economics into medical school curricula, nor formally evaluates medical schools based on the “breadth and depth” to which they teach these topics;⁹ therefore be it

⁹ Liaison Committee on Medical Education. Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree. April 2016.
RESOLVED, That our AMA-MSS encourage a study on the extent to which medical schools and residency programs are teaching topics of healthcare finance and medical economics, with attention paid to the specific content, methods, placement, and amount of said teaching; and be it further

RESOLVED, That our AMA-MSS support our AMA in making a formal suggestion to the Liaison Committee on Medical Education encouraging the addition of a new Element, 7.10, under Standard 7, "Curricular Content," that would specifically address the role of healthcare finance and medical economics in undergraduate medical education.

Fiscal Note: Minimal, 6

Date Received: 04/11/18

RELEVANT AMA AND AMA-MSS POLICY:

Future Directions for Socioeconomic Education H-295.924
The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which "socioeconomic" subjects are covered in the medical curriculum.

Socioeconomic Education for Medical Students H-295.977
1. The AMA favors (a) continued monitoring of U.S. medical school curricula and (b) providing encouragement and assistance to medical school administrators to include or maintain material on health care economics in medical school curricula.

2. Our AMA will advocate that the medical school curriculum include an optional course on coding and billing structure, RBRVS, RUC, CPT and ICD-9.

Development of Courses to Prepare Medical Students and Residents for the Political, Legal and Socioeconomic Aspects of Practice and Physician Advocacy D-296.992
Our AMA will assist local and state medical societies to develop education programs on the political, legal, and socioeconomic aspects of medical practice and physician advocacy, to be offered to medical students and physicians in residency training throughout the country to supplement their clinical education and prepare them for practice.

Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians H-295.864
Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of
model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes.

**Healthcare Economics Education D-295.321**

Our AMA, along with the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, and other entities, will work to encourage education in health care economics during the continuum of a physicians professional life, starting in undergraduate medical education, graduate medical education and continuing medical education.

**Health Policy Education in Medical Schools 295.171MSS**

1) AMA-MSS encourages medical schools to implement teaching strategies that promote outcome based development of behavioral and social science foundations for medical students; and 2) AMA-MSS encourages the AAMC to engage in appropriate follow-up research based on the implementation of its behavioral and socioeconomic report competencies.
AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution 44
(A-18)

Introduced by: Nathanael J. Franks, UT Health San Antonio Long School of Medicine; Anisha Guda, UT Health San Antonio Long School of Medicine; Eric Reuben Smith, UT Health San Antonio Long School of Medicine

Subject: Promoting Awareness Regarding Teledermatology Services for Rural Populations

Referred to: MSS Reference Committee
(Celeste Peay, Chair)

Whereas, 1 in 5 Americans will develop skin cancer by the age of 70 and the five year survival rate for patients who have an early detection of skin cancer is 99%;1 and

Whereas, Across all demographics, there is a shortage in the number of dermatologists in outpatient settings;2 and

Whereas, Access is significantly limited for those covered by Medicaid/Medicare and the uninsured with only 5% of dermatology practices accepting these populations;3 and

Whereas, There are more than 130 million people in the USA who are covered by Medicaid, Medicare, or are uninsured;4 and

Whereas, Rural areas face barriers to healthcare, with lower rates of private insurance coverage compared to metro areas;5,6 and

Whereas, Few dermatologists practice in rural areas and consequently wait times are severely increased,7 which further limits access; and

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Whereas, Rural communities are less likely to engage in skin cancer prevention measures; and

Whereas, There is an increased need to enhance easy access to dermatologic care for patients living in rural areas in order to reduce mortality rates from skin cancer; and

Whereas, Teledermatology has emerged as a cost-effective and reliable way to provide dermatologic care to individuals living in underserved areas; and

Whereas, In a study that was performed in California, over 75% of the patients seen through teledermatology were below the 200% poverty level or lived in rural areas; and

Whereas, Teledermatology allows patients access to dermatologists quickly with limited travel and can maximize the number of patients that are seen; and

Whereas, Teledermatology helps identify patients with susceptibility to skin cancer early which contributes to a better prognosis; and

Whereas, According to the American Academy of Dermatology (AAD), there is a need for policy changes that increase patients’ access to teledermatology services while also promoting awareness about the service; therefore be it

RESOLVED, That our AMA-MSS supports public education announcements regarding teledermatology for medical students and residents of rural communities in order to enhance awareness, promote access, and advocate for the usage of the service, which can contribute to reducing the overall incidence of skin cancer.

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Related AMA Policy: Early Detection and Prevention of Skin Cancer, H-55.972

Our AMA concurs with the policies addressed by the Council on Constitution and Bylaws, Council on Long Range Planning and Development on the early detection and prevention of skin cancer: (1) encourages all physicians to (a) 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; (b) examine their patients' skins for the early detection of melanoma and nonmelanoma skin cancer; (c) urge 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 (d) educate their patients concerning the correct way to perform skin self-examination; (2) supports mechanisms for the education of lay professionals, such as hairdressers and barbers, on skin self-examination to encourage early skin cancer referrals to qualified health care professionals; and (3) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color. Our AMA will continue to work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color.

Access and Equity in Telemedicine Payments D-480.970

Our AMA will advocate that the Centers for Medicare & Medicaid Services pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined shortage areas, if that area can show a shortage of those physician specialists.

Evolving Impact of Telemedicine H-480.974

Our AMA:
(1) will evaluate relevant federal legislation related to telemedicine;
(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
(3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
(5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
(6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
(7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
(8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
(9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services—encrypted and unencrypted.

Coverage of and Payment for Telemedicine H-480.946
1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:
   a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
      - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
      - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
      - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.
   Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.
   b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
   c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
   d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
   e) The delivery of telemedicine services must be consistent with state scope of practice laws.
   f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
g) The standards and scope of telemedicine services should be consistent with related in-person services.
h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
j) The patient's medical history must be collected as part of the provision of any telemedicine service.
k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.
m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.
3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.
4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.
5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.
6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.
7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

**Related MSS Policies:**
Public Education Announcements for Detection of Skin Cancer, 440.012 MSS

Our AMA concurs with the policies addressed by the AMA-MSS: AMA-MSS will ask the AMA to support a public service announcement to increase public awareness of the high incidence of

H-170.969 Teaching Preventive Self-Examinations to High School Students
AMA-MSS Digest of Policy Actions/ 136 The AMA supports the development of comprehensive high school health curricula in conjunction with local medical societies and health departments. This curriculum should include instruction in appropriate self examinations of the skin, breasts, testes and other systems.

(MSS Res 33, I-16) Integration of Telemedicine into Medical Education: The MSS formally establishes support for the following HOD policy: Telemedicine in Medical Education D-295.313
1. Our AMA encourages appropriate stakeholders to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations. 2. Our AMA will collaborate with appropriate stakeholders to reduce barriers to the incorporation of telemedicine into the education of physicians and other health care professionals. 3. Our AMA encourages the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to include core competencies in telemedicine in undergraduate medical education and graduate medical education training. (CME Rep. 06, A-16)
Whereas, In 2015, 2 million Medicare patients age 65 or older were homebound, many with severe chronic conditions and functional impairments making it difficult to visit a doctor; and

Whereas, A 2014 survey of Medicaid users indicated that among disabled adult respondents, 12.2% cited lack of transportation as the main reason for inadequate access to needed care, making it the third greatest reported barrier; and

Whereas, House call programs, which focus on providing primary care services in the homes of vulnerable patients, have significantly reduced healthcare costs and improved medical outcomes; and

Whereas, Specifically, the Independence at Home (IAH) demonstration, which was created to deliver comprehensive primary care for Medicare beneficiaries with multiple chronic conditions through home visits, saved the Centers for Medicare & Medicaid Services (CMS) $25 million in the program’s first performance year (2014-2015; $3,070 per beneficiary) and $10 million in the second (2015-2016; $1,010 per beneficiary); and

Whereas, Patients must live near one of 14 participating health care providers nationwide in order to be eligible for the IAH demonstration, and expanding the project to all eligible beneficiaries could not only save Medicare up to $4.8 billion a year, but also reduce duplicative services and unnecessary hospitalizations; and

Whereas, The Home-based Primary Care (HBPC) program, created by the Veterans Health Administration in 1970 to target patients in the 5% highest cost, has been associated with 24%

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reduction in total cost of VHA care, 9% fewer hospitalizations, 10% fewer emergency department visits, and 23% fewer specialist visits; 7 and

Whereas, As of 2010, HBPC only provided home-based care to a mere 25,000 of the 8.1 million veterans VHA served annually, significantly restricting the program’s cost-savings and impact; 8 and

Whereas, The Maternal and Infant Early Childhood Home Visiting Program (MIECHV), which was established as part of the Patient Protection and Affordable Care Act to provide on-site primary care services to the newborn in low-income families, has reduced childhood healthcare costs, improved newborn health, and prevented child abuse and neglect; 9,10,11 and

Whereas, The MIECHV program represents the largest federal investment in home visits, but it reached only 145,500 parents and children nationwide in 2015 and merely 21 out of the 58 counties in California, leaving many high-risk, low-income families without the home visit resources that promote newborn health and reduce unnecessary emergency department visits; 12,13 and

RESOLVED, That our American Medical Association amend On-site Physician Home Health Care, H-210.981 by addition and deletion to read as follows:

The AMA: (1) recognizes that timely access to physician care for the frail, chronically ill, disabled or low-income patient is a goal that can only be met by an increase in physician house calls to this vulnerable, underserved population.

(2) strongly supports the role of interdisciplinary teams in providing direct care in the patient’s own home, but recognizes that physician oversight of that care from a distance must sometimes be supplemented by on-site physician care through house calls.

(3) advocates that the physician who collaborates in a patient's plan of care for home health services should see that patient on a periodic basis

(4) recognizes the value of the house call in establishing and enhancing the physician-patient and physician-family relationship and rapport, in assessing the effects of the social, functional and physical environment on the patient’s illness, and in incorporating the knowledge gained into subsequent health care decisions.

(5) believes that physician on-site care through house calls is important when there is a change in condition that cannot be diagnosed over the telephone via telemedicine with the assistance of allied health personnel in the home and

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assisted transportation to the physician's office is costly, difficult to arrange, or excessively tiring and detrimental to the patient.
(6) recognizes the importance of improving communication systems to integrate the activities of the disparate health professionals delivering home care to the same patient. Frequent and comprehensive communication between all team members is crucial to quality care, must be part of every care plan, and can occur via telephone, FAX, e-mail, video telemedicine and in person.
(7) recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls, by encouraging the development of programs for low-income families, low-income elderly, and veterans.
(8) supports the requirement for a medical director for all home health agencies, comparable to the statutory requirements for medical directors for nursing homes and hospice.
(9) recommends that all specialty societies address the effect of dehospitalization on the patients that they care for and examine how their specialty is preparing its residents in-training to provide quality care in the home.
(10) encourages appropriate specialty societies to continue to develop educational programs for practicing physicians interested in expanding their involvement in home care.
(11) urges CMS to clarify and make more accessible to physicians information on standards for utilization of home health services, such as functional status, and severity of illness, and socioeconomic status.
(12) urges CMS, in its efforts to redefine homebound, to consider the adoption of criteria and methods that will strengthen the physician's role in authorizing home health services, as well as how such criteria and methods can be implemented to reduce the paperwork burden on physicians.

Fiscal Note:

Date Received: 04/11/18

Relevant AMA Policy

On-Site Physician Home Health Care, H-210.981
The AMA: (1) recognizes that timely access to physician care for the frail, chronically ill or disabled patient is a goal that can only be met by an increase in physician house calls to this vulnerable, underserved population.
(2) strongly supports the role of interdisciplinary teams in providing direct care in the patient's own home, but recognizes that physician oversight of that care from a distance must sometimes be supplemented by on-site physician care through house calls.
(3) advocates that the physician who collaborates in a patient's plan of care for home health services should see that patient on a periodic basis.
(4) recognizes the value of the house call in establishing and enhancing the physician-patient and physician-family relationship and rapport, in assessing the effects of the social, functional and physical environment on the patient's illness, and in incorporating the knowledge gained into subsequent health care decisions.
(5) believes that physician on-site care through house calls is important when there is a change in condition that cannot be diagnosed over the telephone with the assistance of allied health
personnel in the home and assisted transportation to the physician’s office is costly, difficult to arrange, or excessively tiring and painful for the patient.

(6) recognizes the importance of improving communication systems to integrate the activities of the disparate health professionals delivering home care to the same patient. Frequent and comprehensive communication between all team members is crucial to quality care, must be part of every care plan, and can occur via telephone, FAX, e-mail, video telemedicine and in person.

(7) recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls.

(8) supports the requirement for a medical director for all home health agencies, comparable to the statutory requirements for medical directors for nursing homes and hospice.

(9) recommends that all specialty societies address the effect of dehospitalization on the patients that they care for and examine how their specialty is preparing its residents in-training to provide quality care in the home.

(10) encourages appropriate specialty societies to continue to develop educational programs for practicing physicians interested in expanding their involvement in home care.

(11) urges CMS to clarify and make more accessible to physicians information on standards for utilization of home health services, such as functional status and severity of illness.

(12) urges CMS, in its efforts to redefine homebound, to consider the adoption of criteria and methods that will strengthen the physician’s role in authorizing home health services, as well as how such criteria and methods can be implemented to reduce the paperwork burden on physicians.

Providing Cost Estimate with Home Health Care Order Authorization H-210.996

The AMA urges physicians to request home health care providers to provide a cost estimate with the physician authorization form, when the form is sent to the physician for his/her signature.

Medicaid Patient-Centered Medical Home Models H-160.913

Our AMA: (1) recognizes that the physician-led medical home model, as described by Policy H-160.919, has demonstrated the potential to enhance the value of health care by improving access, quality and outcomes while reducing costs; and (2) will work with state medical associations to explore, and where feasible, implement physician-led Medicaid patient-centered medical home models based on the unique needs of the physicians and patients in their states.
Resolution: 46
(A-18)

Introduced by: Region 7; Lauren Colburn, University of Connecticut School of Medicine

Subject: Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing

Referred to: MSS Reference Committee
(Celeste Peay, Chair)

Whereas, Surveys indicate that the majority (95% of males and 75% of females) of individuals have at least some lifetime exposure to pornographic material;\(^1\) and

Whereas, In 2017, the Problematic Pornography Consumption Scale (PPCS) was developed to distinguish between nonproblematic and problematic pornography use and in a study of 772 respondents using the PPCS, 3.6% of pornography users belonged to the at-risk group;\(^2\) and

Whereas, Individuals suffering from problematic pornography use may have impaired daily functioning that includes, but is not limited to, hardship on romantic relationships and job loss due to the inability to control urges to view pornography at work;\(^3\) and

Whereas, The Kinsey Institute survey found that 9% of porn viewers reported that they had tried unsuccessfully to stop;\(^4\) and

Whereas, There is emerging evidence that the meso-limbic-frontal regions of the brain that are associated with reward pathways are active and that there is dopaminergic and serotonergic neurotransmitter dysregulation similar to that of addictive disorders;\(^4,5\) and

Whereas, A number of studies have linked problematic pornography use to increased incidence of erectile dysfunction\(^6\) and higher rates of domestic violence;\(^7,9\) and

Whereas, During the drafting of the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) in 2012, it was proposed that the addictive disorders category develop a new diagnosis called hypersexual disorder with a pornography subtype, but reviewers determined that there was not yet enough evidence to include the diagnosis in the 2013 publication;\(^1\) and

Whereas, AMA policy supports protecting youth from viewing pornography (H-60.934) and creating awareness about victims of child pornography and abuse (H-60.990) and the AMA has no policy pertaining to adult pornography use or potential misuse, and be it further,

RESOLVED, Our AMA supports research on problematic pornography use, including its physiological and environmental drivers, appropriate diagnostic criteria, effective treatment options, and relationships to erectile dysfunction and domestic violence.
Fiscal Note: Minimal, 5

Date Received: 04/11/2018

RELEVANT AMA AND AMA-MSS POLICY

Child Pornography H-60.990

The AMA (1) encourages and promotes awareness of child pornography issues among physicians; (2) promotes physician awareness of the need for follow-up psychiatric treatment for all victims of child pornography; (3) encourages research on child abuse (including risk factors, psychological and behavioral impact, and treatment efficacy) and dissemination of the findings; and (4) wherever possible, encourages international cooperation among medical societies to be alert to and intervene in child pornography activities.

Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934

Our AMA (1) Recognizes the positive role of the Internet in providing health information to children and youth; (2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography; (3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet; (4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use; and (5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.

References:

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution 47
(A-18)

Introduced by: Region 5; Region 6; Arshjot Khokhar, Dallas Hamlin, Pennsylvania State University College of Medicine; Tabitha Moses, Wayne State University School of Medicine; Eun Kyung Ellen Kim, University Massachusetts Medical School;

Subject: Addressing the Need for Standard Evidenced-Based Screening Tools to Improve Care of Adolescent and Pediatric Patients with Depression

Referred to: MSS Reference Committee
(Celeste Peay, Chair)

1 Whereas, Point prevalence of depression is 1-2% in children under the age of 11 and 12.7% in adolescents, age 12 -18;¹ and

2 Whereas, Depression is a leading risk factor for suicide in adolescents, and rates of suicide have increased in the last ten years to 14% and 5% in adolescent males and females respectively;²,³ and

3 Whereas, Diagnosis and treatment of adolescent depression is delayed as long as 8 to 10 years after onset of symptoms, not allowing for early intervention;⁴ and

4 Whereas, It has been shown that there are effective treatments for pediatric and adolescent depression, such as medication and psychotherapy;⁵,⁶ and

5 Whereas, From 2005 to 2015, depression screening rates were 0.2% for patients ages 12 to 18 and 80% less in minority pediatric populations illustrating a lack of preventative screening;⁷ and

6 Whereas, Surveys conducted by the American Academy of Pediatrics revealed that primary care physicians believed they should screen for depression in children more but felt they lacked the knowledge, skills, and tools to do so effectively;⁸ and

7 Whereas, The American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry have advocated for the implementation of a validated tool for universal

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routine pediatric and adolescent depression screenings to help mitigate the rising rates of depression in these populations.\textsuperscript{9, 10} and 

Whereas, Current tools like Beck’s Depression Inventory have been criticized for gender bias because of high rates of false positives in females;\textsuperscript{11} and 

Whereas, Proposed screening tools, like PHQ-2 and PHQ-9, have been criticized for their lack of cross cultural utility resulting in bias against minority ethnic groups;\textsuperscript{11} and 

Whereas, The United States Preventative Services Task Forces (USPSTF) identified a critical research gap in studies validating current screening tools for depression in children less than 11 years old;\textsuperscript{12} and 

Whereas, The USPSTF and independent researchers found no studies that directly validated current screening tools for depression in adolescents to provide long-term benefit;\textsuperscript{13} and 

RESOLVED, That our AMA-MSS amend the policy 345.003MSS Improving Pediatric Mental Health Screening 

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) recognize the lack of validated screening tools for pediatric mental illness and promote the research into the validation, development, and implementation of evidence-based routine mental health screenings; and (3) 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.


\textsuperscript{10} Wagner KD. Presidential Address: Depression Awareness and Screening in Children and Adolescents. Journal of the American Academy of Child & Adolescent Psychiatry. 2018;57(1):6- 


RELEVANT AMA AND AMA-MSS POLICY

Preventive Services H-425.997
1. Our AMA encourages the development of policies and mechanisms to assure the continuity, coordination and continuous availability of patient care, including professional preventive care and early-detection screening services, provided the services are cost effective.
2. It is the policy of the AMA that any preventive service that is being considered for inclusion in public or private sector insurance products have evidence-based data to demonstrate improved outcomes or quality of life and the cost effectiveness of the service.
3. Our AMA believes that preventive care should ideally be coordinated by a patient's physician.

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.
4. Our AMA recognizes the impact of violence and social determinants on women’s mental health.

Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination D-420.991
Our AMA: (1) will work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; (2)
encourages the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways; and (3) encourages the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up maternal mental health care.

345.003 MSS Improving Pediatric Mental Health Screening
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.
WHEREAS, The United States has the highest rate of incarceration in the world;¹ and

WHEREAS, An estimated 2.7 million children have at least one parent incarcerated in the United States;² and

WHEREAS, Children with incarcerated parents may face challenging childhood experiences, such as financial hardship and exposure to drug and alcohol abuse, among others;³ and

WHEREAS, In a 2013 study, significant associations were found between parental incarceration and health problems, including depression, posttraumatic stress disorder, anxiety, hyperlipidemia, asthma, migraines, HIV/AIDS, and fair/poor health in adjusted logistic regression models;¹ and

WHEREAS, Early childhood interventions for at-risk youth have demonstrated improved health outcomes and health behaviors;⁴ and

WHEREAS, Providing children with coping strategies and additional emotional resources, such as mentors, trained teachers, skilled counselors, and strong foster families can help children feel comforted and secure throughout a parent’s incarceration;⁵ and

WHEREAS, The National Resource Center on Children and Families of the Incarcerated is coming out with a report fall of 2018 to survey state initiatives that identify effective strategies in reducing the impact of parental incarceration on children;⁶ and

⁵ Recognizing the importance of providing services to children of incarcerated parents, H.Res.623, 115th Congress. (2017).
WHEREAS, The House of Representatives has introduced a resolution (H.Res.623) that recognizes the importance of providing services to children of incarcerated parents; therefore, be it

RESOLVED, That our AMA recognize the unique challenges facing children who are growing up with one or both parents in prison; and be it further

RESOLVED, That our AMA support federal and state legislation and other initiatives that help to further target the specific needs of children of incarcerated parents by providing resources and services.

Fiscal note: Moderate, 10

Date received: 4/11/2018

RELEVANT AMA POLICY:

Long-Term Care Residents With Criminal Backgrounds H-280.948

1. Our AMA encourages the long-term care provider and correctional care communities, including the American Medical Directors Association, the Society of Correctional Physicians, the National Commission on Correctional Health Care, the American Psychiatric Association, long-term care advocacy groups and offender advocacy groups, to work together to develop national best practices on how best to provide care to, and develop appropriate care plans for, individuals with violent criminal backgrounds or violent tendencies in long-term care facilities while ensuring the safety of all residents of the facilities.
2. Our AMA encourages more research on how to best care for residents of long-term care facilities with criminal backgrounds, which should include how to vary approaches to care planning and risk management based on age of offense, length of incarceration, violent tendencies, and medical and psychiatric history.
3. Our AMA encourages research to identify and appropriately address possible liabilities for medical directors, attending physicians, and other providers in long-term care facilities caring for residents with criminal backgrounds.
4. Our AMA will urge the Society of Correctional Physicians and the National Commission on Correctional Health Care to work to develop policies and guidelines on how to transition to long-term care facilities for individuals recently released from incarceration, with consideration to length of incarceration, violent tendencies, and medical and psychiatric history.

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

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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.

**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.
Whereas, Medical students and those that have graduated with medical degrees and passed
the United States Medical Licensing Examination (USMLE) exams or Comprehensive
Osteopathic Medical Licensing Examination (COMLEX) exams are not guaranteed placement in
a residency program and 8,063 residency applicants did not match in 2018;¹ and

Whereas, The stated purpose of the USMLE is assessment for licensure but it is used by
residency programs for resident selection²³; and

Whereas, There is a shortage of primary care providers in the United States of America⁴; and

Whereas, The “Arkansas Graduate Registered Physician Act” defines a “graduate registered
physician” as a graduate of an accredited medical school that has passed Step 1 and Step 2
USMLE or COMLEX that is a dependent medical practitioner who only provides care under the
supervision of a physician and can only practice under this license for a maximum of three
years⁵; and

Whereas, the Kansas Medical Society lobbied the Kansas State legislature to create a special
license for University of Kansas School of Medicine graduates who do not match into a
residency program to practice under a physician in a medically underserved area for a
maximum of two years⁶; and

⁵ O’Dwyer, K. Arkansas Graduate Registered Physicians Act (2016). Retrieved from http://170.94.43.152/REGS/060.00.00.00.00.01 Đại quỹ 16505.pdf
Whereas, Kansas State Statute §65-2811a allows University of Kansas School of Medicine graduates who have not matched into a residency placement to receive a special license to provide care under a physician for a maximum of two years; and

Whereas, Missouri state Statute §334.036 defines an “assistant physician” as a medical school graduate who has passed Step 1 and Step 2 of USMLE or equivalent licensure exam and has not completed a residency that is allowed to practice primary care in underserved areas; and

Whereas, There is no published data on the efficacy or safety of the aforementioned programs that allow medical school graduates who do not match into a residency program to practice in limited capacity; and

Whereas, The Coalition for Patients First, of which The American Medical Association is a member organization, opposed the creation of “assistant physician” programs and stated concerns about such programs resulting in program participants having limited supervision and that this lack of supervision may jeopardize patient safety; and

Whereas, Current AMA policy H-160.949, Practicing Medicine by Non-Physicians “opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education”; (H-160.949); therefore be it

RESOLVED, That our AMA
(A) reaffirm its opposition to special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education;
(B) encourage the creation of a rigorous, standardized process for programs that already exist instituted by state laws allowing restricted practice by medical school graduates who have passed medical licensure exams but have not matched into a residency program, to allow states to evaluate such programs to ensure that there is proper oversight of program participants by licensed physicians, ensure that patient safety standards are upheld, and ensure that participants in such programs re-enter the residency match.
(C) encourage the aforementioned programs to publish data including but not limited to information regarding enrollment, rate of successful residency match re-applicants from the programs, any benefits or harms that members of underserved communities receive from such programs, and any patient safety incidents so as to determine the efficacy and safety of such programs.

7 Special Permits; Issuance; Conditions and Qualifications; Limitations on Practice; Expiration of Permit, 65-2811a §. Retrieved from http://www.ksrevisor.org/statutes/chapters/ch65/065_028_0011a.html
9 Coalition for Patients First, Protecting Patient Care & Preserving Health Equity, 2016, Retrieved on 4/11/18 from https://drive.google.com/file/d/1yyWjpKKZ5zsmhSCDjVbqSntZCQ75c/view
RELEVANT AMA AND AMA-MSS POLICY

Practicing Medicine by Non-Physicians H-160.949
Our AMA:
(1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;
(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and
(6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.

Medical Licensure H-275.978
The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;
(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;
(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;
(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;
(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the
health, safety and welfare of the public;
(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);
(7) urges licensing boards to maintain strict confidentiality of reported information;
(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;
(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;
(10) urges all physicians to participate in continuing medical education as a professional obligation;
(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;
(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;
(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;
(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;
(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;
(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;
(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;
(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;
(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;
(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;
(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and
encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.

**Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934**

Our AMA adopts the following principles:

1. Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training.

2. All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content.

3. There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA.

4. Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians.

5. Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements.

6. There should be no reporting of actions against medical students to state medical licensing boards.

7. Medical schools are responsible for identifying and remedying and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems as well as gaps in student knowledge and skills.

8. The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.

**The Residency Match Process 310.001 MSS**

The AMA-MSS recognizes the significant time, energy, and resources that are allocated to the residency match process and hereby supports to following principles to help improve the residency match process:

1. That the AMA-MSS will continue to work with other student, resident, and physician organizations to research and promote changes in the structure and/or the rules governing the Match so as to maximize the advantage to medical students and residents.

2. That the AMA-MSS supports efforts to encourage residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules.

3. That the AMA-MSS supports efforts to encourage the ACGME, the AOA, and other involved organizations to strongly encourage residency programs that now require a preliminary year to
match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.

4. That the AMA-MSS supports a change in the NBME policy to report examination scores as “pass-fail” only.

5. That the AMA-MSS encourages individual chapters to maintain a roster of students willing to host residency applicants when they visit their institution.

6. That the AMA-MSS will ask the AMA to work with the NRMP to keep transaction costs of the Match to reasonable levels, and ensure that fees charged for each program a medical student applies to be capped at a reasonable level that takes into account medical students’ budgeting constraints.

7. That the AMA-MSS will ask the AMA to support students, residents, and all appropriate organizations who work to ensure that any suspected violation of NRMP policy is addressed, publicized, and proper redress achieved, including the active promotion of NRMP complaint forms and other existing channels.

8. That the AMA-MSS will ask the AMA to urge the NRMP to allow students to opt out of the Match without penalty when there are extenuating circumstances, including but not limited to: unforeseen family emergencies such as illness that would require the individual to care for a family member; unforeseen physical or mental health problems that would impede the individual’s ability to participate in residency training and required military or foreign service duty.

9. That the AMA-MSS will ask the AMA to support the concept that programs should retain the ability to extend applicants positions outside the Match.

10. That the AMA-MSS will ask the AMA to support improvements to the structure of the Match program for efficient placement of unmatched students, as long as such alterations do not result in postponement of the traditional “Match Day” date in midMarch. (MSS GC Rep A, I-16).
Resolution: 50
(A-18)

Introduced by: Jack Haberl and Katrice Karanfilian
Rutgers-New Jersey Medical School

Subject: Support for medical school community outreach programs focusing on health education and preventive services in student-run clinics

Referred to: MSS Reference Committee
(Celeste Peay, Chair)

Whereas, low income is associated with sedentary lifestyle and obesity, as well as a higher prevalence and risk of CHD, hypertension, and type II diabetes;¹² and

Whereas, low health literacy and education is associated with poor health status and cardiovascular disease;³⁴ and

Whereas, people with a low-income and less education tend to have less knowledge about nutrition and parental nutrition knowledge has been associated with lower adiposity in children;⁵,⁶ and

Whereas, low education and poor health literacy have been shown to contribute to low adherence to medication and treatment of a chronic illnesses such as rheumatoid arthritis;⁷ and

Whereas, a high-quality diet can lead to decreased mortality from cardiovascular disease, cancer, and other chronic diseases;⁸ and

Whereas, interventions to provide education on the importance of nutrition and physical activity have led to positive behavioral changes and a reduction in weight and obesity;⁹,¹⁰,¹¹,¹² and

Whereas, knowledge regarding prevention and treatment of chronic disease influences mortality, as seen with colorectal cancer mortality rates;¹³ and

Whereas, increased knowledge about diabetes is an important factor in glycemic control in low-income populations with type II diabetes;¹⁴ and

Whereas, education programs regarding diabetes management at student-run clinics have demonstrated the ability to facilitate clinical improvement one year after enrollment;¹⁵ and

Whereas, over 75% of U.S. AAMC member institutions maintain student-run free clinics, up from close to 50% in 2005;¹⁶,¹⁷ and

Whereas, these medical school student-led free clinics result in students caring more about underserved populations, and generate more student interest in primary care;¹⁸ and

Whereas, these Medical School and Community Outreach Program partnerships have the potential to benefit both parties through medical training and patient treatment and education;¹⁹ and
Whereas, the most common education topics covered during educational health programs at student-run free clinics are hypertension, type II diabetes, and smoking cessation;\(^{20}\) and

Whereas, rates of preventative care services in student-run clinics fall below Healthy People 2020 goals in several categories, including blood pressure, diabetes, diet control, STD, and tobacco use and cessation screenings;\(^{21}\) and

Whereas, existing AMA policy regarding student-run clinics does not currently emphasize the role of patient education and preventative care in these clinics (H-160.953, 160.004MSS); therefore be it

**RESOLVED,** That our AMA-MSS encourage medical students to establish and participate in community outreach programs within the framework of existing student-run clinics, thus giving medical students a clear role towards improving health outcomes in underserved communities and increasing the low rates of preventative care services already provided in these medical school-based clinics.

Fiscal Note: Minimal, 4

Date Received: 04/11/18

**References:**


**RELEVANT AMA AND AMA-MSS POLICY:**

**Free Clinics H-160.953**

The AMA: (1) encourages the establishment of free clinics as an immediate partial solution to providing access to health care for indigent and underserved populations; (2) will explore the potential for a partnership with state and county medical societies to establish a jointly-sponsored free clinic pilot program to provide health services and information to indigent and underserved populations; and (3) will develop strategies that will allow the AMA, along with one or more state or county medical societies, to join in partnership with private sector liability insurers and government - especially at the state, county, and local levels - to establish programs that will have appropriate levels of government pay professional liability premiums or...
indemnify physicians who deliver free services in free clinics or otherwise provide free care to the indigent. (BOT Rep. 27-A-94) (Reaffirmed: BOT 17, A-04) (Reaffirmed: CME Rep. 6, A-12)

**Primary Care Physicians in the Inner City H-200.972**

Our AMA should pursue the following plan to improve the recruitment and retention of physicians in the inner city:

(1) Encourage the creation and pilot-testing of school-based, church-based, and community-based urban "family Health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.

(2) Encourage the affiliation of these family health clinics with urban medical schools and teaching hospitals.

(3) Promote medical student rotations through the various inner-city neighborhood family health clinics, with financial assistance to the clinics to compensate their teaching efforts.

(4) Encourage medical schools and teaching hospitals to integrate third- and fourth-year undergraduate medical education and residency training into these teams.

(5) Advocate the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.

(6) Study the concept of having medical schools with active outreach programs in the inner city offer additional training to physicians from nonprimary care specialties who are interested in achieving specific primary care competencies.

(7) Consider expanding opportunities for practicing physicians in other specialties to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family practice, internal medicine, pediatrics, etc. These may be developed so that they are part-time, thereby allowing physicians enrolling in these programs to practice concurrently.

(8) Encourage the AMA Senior Physicians Services Group to consider the use in underserved urban settings of retired physicians, with appropriate mechanisms to ensure their competence.

(9) Urge urban hospitals and medical societies to develop opportunities for physicians to work part-time to staff urban health clinics.

(10) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who serve the inner-city poor.

(11) Urge medical schools to seek out those students whose profiles indicate a likelihood of practicing in underserved urban areas, while establishing strict guidelines to preclude discrimination.

(12) Encourage medical school outreach activities into secondary schools, colleges, and universities to stimulate students with these profiles to apply to medical school.

(13) Encourage medical schools to continue to change their curriculum to put more emphasis on primary care.

(14) Urge state medical associations to support the development of methods to improve physician compensation for serving this population, such as Medicaid case management programs in their respective states.

(15) Urge urban hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to fill gaps in urban care.

(16) Urge CMS to explore the use of video and computer capabilities to improve access to and support for urban primary care practices in underserved settings.

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

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

Increasing the Availability of Primary Care Physicians H-200.973

It is the policy of the AMA that:

(1) Each medical school should reexamine its institutional goals and objectives, including the extent of its commitment to primary care. Those schools recognizing a commitment related to primary care should make this an explicit part of the mission, and set institutional priorities accordingly.

(2) The admission process should be sensitive to the institution's mission. Those schools with missions that include primary care should consider those predictor variables known to be associated with choice of these specialties.

(3) Through early recruitment and outreach activities, attempts should be made to increase the pool of applicants likely to practice primary care.

(4) Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective.

(5) All four years of the curriculum in every medical school should provide experiences in primary care for all students. These experiences should feature increasing levels of student responsibility and use of ambulatory and community settings.

(6) The visibility of primary care faculty members should be enhanced within the medical school and positive attitudes toward primary care among all faculty members should be encouraged.

(7) Medical schools should provide career counseling related to the choice of a primary care specialty.

(8) The curriculum in primary care residency programs and the sites used for training should be consistent with the objective of training generalist physicians.

(9) There should be increased financial incentives for physicians practicing primary care.

(10) Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, and enhanced efforts to eliminate "hassle" and unnecessary paper work should be undertaken.

(11) There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

(12) States should be encouraged to provide positive incentives--such as scholarship or loan repayment programs, relief of professional liability burdens and reduction of duplicative administrative responsibilities--to support medical students' choice of a primary care specialty. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

(Reaffirmed: CME Rep. 1, I-08)

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. (BOT Rep. 4, A-03) (Reaffirmation A-11)
(Reaffirmation: A-16)
Whereas, There are more than 116,000 people who are on the organ transplant waiting list as of August 2017 and 20 people die every single day from lack of a transplant in the United States and 1

Whereas, 95% of US citizens support organ donation, only 54% are registered as an organ donor2 and

Whereas, The current opt-in organ donation model requires that an individual voluntarily and actively registers to become an organ donor but do not have to make a decision if they do not wish. It has only resulted in a 38% organ donation rate,3 and

Whereas, This resolution is based on a mandated choice model where individuals will first be given information about organ donation through a centralized organ donation website when they register for a driver’s license and 4,5

Whereas, Current organ registry campaigns have not raised a great deal of awareness, this law will use technology to increase marketing of the registry. A website will be created where people can view and change their organ donation without having to go to a state or local government office. With the latter, the donor must sign that they fully understand what organ donation means and that their decision is legally binding. 6

Whereas, The organ donation website will serve to provide education about the policy to promote transparency about the registry.7

Whereas, The mandated choice model ensures that each individual decides whether or not to be an organ donor when completing any state or national government activity such as registering for a driver’s license, obtaining a voter’s card, filing taxes, etc. Similarly, at each of these venues and on the proposed website, individuals are able to change their choice (go from not being an organ donor to being an organ donor or vice versa) but they must make a decision, and

Whereas, The organ donation policy in Illinois that is opt-out has led to a 60% increase in organ donation. This law can be used as a model for this resolution and

Whereas, AMA policy to “further study to determine whether either or both can be implemented in a way that meets fundamental ethical criteria for informed consent and provides clear evidence that their benefits outweigh ethical concerns.” (6.1.4) and “to evaluate the model of mandated choice and presumed consent” (H-370.959) there is no policy to adopt a mandated choice system with detailed educational components. Other policies (H-370.998) encourage increasing organ donation within the current opt-in system as opposed to a shift to a new paradigm of mandated choice. Therefore, be it

RESOLVED, Our AMA-MSS supports a mandated choice organ donation program where individuals must choose whether or not they would like to be organ donors. If upon death, the person has not indicated whether they would like to be an organ donor, their next of kin has the right to decide.

RESOLVED, Our AMA-MSS supports providing both information about organ donation and an opportunity to change organ donation status at all local and state government offices, not just the Department of Motor Vehicles to maximize awareness and autonomy.

RESOLVED, Our AMA-MSS supports creating a nationwide website to give individuals information about organ donation to educate citizens so they make an informed decision.

Fiscal Note: Minimal, 5

Date Received: 04/11/18

RELEVANT AMA AND AMA-MSS POLICY

1. 6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors
   This resolution allows for a pilot study to determine the ethical basis of both presumed consent and mandated choice organ donation models.

2. H-370.959 Methods to Increase the US Organ Donor Pool. This resolution supports studying presumed consent and mandated choice and educating the public about organ donation.

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9 Thaler, Richard H. “Opting in vs. Opting Out”

3. **H-370.998 Organ Donation and Honoring Organ Donor Wishes.** This resolution encourages citizens to fill out organ donation cards and if there is no family during time of death, organ donation can proceed.

4. **H-370.996 Organ Donor Recruitment.** This resolution states that the AMA supports exploring methods to greatly increase organ donation such as the “presumed consent” modality of organ donation.
AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution 52
(A-18)

Introduced by: Georgetown University School of Medicine Section; Landon Hobbs, University of Virginia School of Medicine; Christopher Davis, Penn State College of Medicine

Subject: Encouraging Pharmaceutical Price Transparency at the Point of Sale

Referred to: MSS Reference Committee (Celeste Peay, Chair)

Whereas, Prescription drug prices are on the rise in America with the U.S. spending $1443 per capita on pharmaceuticals in 2016;1, 2 and

Whereas, In recent years the pricing of certain prescription drugs has risen dramatically;3 and

Whereas, Examples of medications that have substantially increased in price include daraprim, which increased from $3.50 to $750 per pill, and Epipen has grown from $100 in 2009 to $600 in 2016 for a 2-pack of autoinjectors;4, 5 and

Whereas, This increase in drug prices has increased co-pay for many patients, leading to a greater financial burden;6 and

Whereas, Increased drug prices and financial burden has been shown to negatively impact patients’ medication compliance;7 and

5 Naren P. Tallapragada; Off-patent drugs at brand-name prices: a puzzle for policymakers, Journal of Law and the Biosciences, Volume 3, Issue 1, 1 April 2016, Pages 238–247
Whereas, Tools such as, but not limited to, NeedyMeds, RxAssist, GoodRx provide patients with opportunities to lower costs by means of manufacture copay cards, prescription assistance programs, disease based assistant programs, and available coupons for prescription medication; and

Whereas, Pharmacists are in a unique position to directly address increased drug pricing at the point of dispensing medication; and

Whereas, Increased use of cost reducing programs for insured and uninsured has the potential to decrease overall health care costs and direct financial burden on the patient; and

Whereas, Although H-110-987 establishes AMA support for cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies, but no such policy applies to cost transparency between consumers and said organizations; and

Whereas, H-110-988 encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs; and

Whereas, H-110-911 establishes AMA support for disclosure of co-pay and actual retail price at the pharmacy level, but no current MSS policy exists on disclosure of cost-reducing programs at the point of dispensing medication; and

RESOLVED, That our AMA encourage pharmacies to provide unsolicited information on cost-reducing programs to patients prior to distributing medication.

RESOLVED, That our AMA reaffirm the development of additional cost-reducing programs for patient medication.

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RELEVANT AMA AND AMA-MSS POLICY

Cost of Prescription Drugs H-110.996
Our AMA supports increasing physician awareness about the cost of drugs prescribed for their patients. Res. 173, A-91; Reaffirmed: Res. 520, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09

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. BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99

Pharmaceutical Costs 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.

10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.

**Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988**

1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.

2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.

3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.

4. Our AMA supports measures that increase price transparency for generic prescription drugs.
Price of Medicine H-110.991
Our AMA (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications, and (2) will pursue legislation requiring pharmacies to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication. CMS Rep. 6, A-03; Appended: Res. 107, A-07

Private Health Insurance Formulary Transparency H-125.979
1. Our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing. 2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term. 3. Our AMA will develop model legislation (a) requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic, (b) requiring insurance carriers to make this information available to consumers by October 1 of each year and, (c) forbidding insurance carriers from making formulary deletions within the policy term. 4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours. 5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription. 6. Our AMA (a) promotes the value of online access to upto-date and accurate prescription drug formulary plans from all insurance providers nationwide, and (b) supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans. Sub. Res. 724, A-14; Appended: Res. 701, A-16

Patient Information and Choice Our AMA supports the following principles H-373.998
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 should 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.

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.

**100.014 MSS Drug Pricing Reform:**

AMA-MSS (1) supports enabling Medicare and other federal health systems to negotiate drug prices with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies for their state-run health programs; and (2) supports legislation that requires increased transparency and public accessibility to drug manufacturing costs from all players in the drug supply production chain, including but not limited to: drug manufacturers, pharmaceutical company marketing information, pharmaceutical research and development costs and distribution companies. (MSS Res 21, I-15)

**155.003 MSS Price Transparency in Health Care:**

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. (MSS Amended AMA-MSS Digest of

315.007 MSS Integration of Drug Price Information Into Electronic Medical Records:
Our AMA-MSS will ask the AMA to (1) support the incorporation of estimated patient out of
pocket drug costs into electronic medical records in order to help reduce patient cost burden;
and (2) collaborate with invested stakeholders, such as physician groups, Electronic Medical
Records (EMR) vendors, hospitals, insurers, and governing bodies to integrate estimated out
AMA-MSS Digest of Policy Actions/ 89 of pocket drug costs into electronic medical records in
order to help reduce patient cost burden. (MSS Res 01, I-16) (AMA Res 219, A-17 Referred)
315.007MSS Integration of Drug Price Information Into Electronic Medical Records: Our AMA-
MSS will ask the AMA to (1) support the incorporation of estimated patient out of pocket drug
costs into electronic medical records in order to help reduce patient cost burden; and (2)
collaborate with invested stakeholders, such as physician groups, Electronic Medical Records
(EMR) vendors, hospitals, insurers, and governing bodies to integrate estimated out AMA-MSS
Digest of Policy Actions/ 89 of pocket drug costs into electronic medical records in order to help
reduce patient cost burden. (MSS Res 01, I-16) (AMA Res 219, A-17 Referred)
Whereas, Effective healthcare advocacy by professional organizations rests in part within its members' wealth of experience, knowledge of government, policy and issues, and Civic literacy is defined as the knowledge regarding American government, the American political system, the roles of citizens, lawmakers and political actors, and skills of effective citizenship; and

Whereas, Research in political science, social work and education has shown that civic literacy amongst citizens, professionals and students is a significant factor in active civic engagement, and Whereas, While studies and initiatives aimed at improving physician civic engagement and legislative awareness have explored factors affecting physician engagement, an evaluation of civic and healthcare policy literacy amongst US medical students, trainees, and professionals has yet to be performed; and

5 Ross, Janke, Boyle et al. 2013
8 Mccabe, Hylton, Kooreman et al. 2016
Whereas, As the AMA continues to be a leading voice in shaping U.S. healthcare policy, it is imperative to ensure that future-physicians have the civics and policy education needed to successfully navigate the political landscape of healthcare; and

Whereas, While the Liaison Committee on Medical Education, AMA and AMA-MSS have encouraged the incorporation of healthcare policy and social science core competencies in medical education curricula, studying the effectiveness of AMA-supported civic and policy education initiatives is made difficult without periodic civic and healthcare literacy assessments of medical students, trainees and professionals (AMA Policy H-295.953, G-615.103) (AMA-MSS Policy 295.153MSS, 295.171MSS, 295.173MSS, 565.004MSS); therefore be it

RESOLVED, That our AMA-MSS support a periodic formal assessment of civic and healthcare policy literacy among US medical students.

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13 Liaison Committee on Medical Education, author. Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree. Liaison Committee on Medical Education; 2018. March
Fiscal Note: Minimal, 5

Date Received: 03/28/18

RELEVANT AMA AND AMA-MSS POLICY

Relevant AMA Policy:
H-295.953--Medical Student, Resident and Fellow Legislative Awareness
G-615.103--Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy

Relevant AMA-MSS Policy:
295.153MSS--Health Policy Education in Medical Schools
295.171MSS--Health Policy Education in Medical Schools
295.173MSS--Policy and Advocacy Rotations for Medical Students
565.004MSS--Policy and Advocacy Opportunities for Medical Students
Whereas, In the United States, all international medical graduates, including those who have
completed prior international graduate medical education, must complete an Accreditation
Council of Graduate Medical Education-accredited residency program, typically lasting 3 years
or longer, in order to obtain licensure to practice medicine in the United States;¹ and

Whereas, Currently 24% of physicians in residency programs in the United States are
international medical graduates;² and

Whereas, A Pubmed search on 11 April 2018 failed to find any results describing what
percentage of international medical graduates training in residency programs in the United
States have completed prior international graduate medical education;³ and

Whereas, International medical graduates who have completed prior international graduate
medical education, international medical graduates without prior graduate medical education,
and domestic medical graduates compete for a finite number of residency positions;⁴ and

Whereas, There is a projected shortage in the United States of between 7,300 and 43,100
physicians in primary care specialties, and between 33,500 and 61,800 physicians in non-
primary care specialties by 2030;⁵ and

Whereas, An alternative licensure pathway for international medical graduates with prior
international graduate medical education that circumvents residency training could address the

² GME Track. Table B3. Number of Active Residents, by Type of Medical School, GME Specialty, and Sex. Association of American Medical Colleges; 2017.
³ PubMed search criteria included the following keyword combinations: “international OR foreign” AND “national resident matching program” AND “graduate medical education”, international medical graduate[Title], and “international medical graduate” AND “graduate medical education”
projected physician shortage in the United States by lowering barriers and creating incentives for international medical graduates with prior international graduate medical education to practice medicine in the United States;⁶ and

Whereas, An alternative licensure pathway for international medical graduates with prior international graduate medical education that circumvents residency training could address the projected physician shortage in the United States by making available residency positions for other applicants that would have otherwise been filled by physicians obtaining licensure through the alternative pathway;⁷ therefore be it

RESOLVED, That our AMA support investigation into the demographics of international medical graduates who have completed prior international graduate medical education in residency programs in the United States; and be it further,

RESOLVED, That our AMA support investigation into whether providing an alternative licensure pathway for international medical graduates who have completed prior international graduate medical education could address the impending physician shortage in the United States; and be it further,

RESOLVED, That our AMA study the feasibility of implementation of an alternative licensure pathway for international medical graduates who have completed prior international graduate medical education.

RELEVANT AMA AND AMA-MSS POLICY

Abolish Discrimination in Licensure of IMGs
H-255.966
1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):

A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.

B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.

C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.

D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.

E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.

2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.

3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.

4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.

Oppose Discrimination in Residency Selection Based on International Medical Graduate Status
D-255.982
1. Will request that the Accreditation Council for Graduate Medical Education include in the Institutional Requirements a requirement that will prohibit a program or an institution from having a blanket policy to not interview, rank or accept international medical graduate applicants.
2. Recognizes that the assessment of the individual international medical graduate residency and fellowship applicant should be based on his/her education and experience.

3. Will disseminate this new policy on opposition to discrimination in residency selection based on international medical graduate status to the graduate medical education community through AMA mechanisms.

**AMA Principles on International Medical Graduates**

**H-255.988**

Our AMA supports:

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.

2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.

3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.

4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.

5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.

6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.

7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.

8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.

9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.

10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.

11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.

12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.

13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.

16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.

19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.

20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.

22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

Graduates of Foreign Health Professional Schools

H-255.985

(1) Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States' programs. Agencies recognized to license or certify health professionals in the United States should have mechanisms to evaluate the entry-level competence of graduates of foreign health professional programs. The level of competence and the means used to assess it should be the same or equivalent to those required of graduates of U.S. accredited programs. (2) All health
care facilities, including governmental facilities, should adhere to the same or equivalent licensing and credentialing requirements in their employment practices.

Alternate Licensure Protocols for IMGs
D-255.997
Our AMA will actively support the Florida Medical Association in pursuing legislation that would require the Florida Department of Health to prevent and negate separate criteria for International Medical Graduates to become licensed as Florida physicians.

Foreign Medical Graduates
H-255.987
1. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the US regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.

2. Our AMA will: (a) continuously study challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce; and (b) lobby members of the US Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

Licensure of International Medical Graduates
255.003MSS
AMA-MSS supports equivalent licensing requirements for all physicians seeking licensure in the US, and opposes the development of separate licensing criteria, including exams, for any group.

The Status of Foreign Medical School Graduates in the United States
255.000MSS
AMA-MSS supports the following principles: (1) The US Government should provide preferential support (e.g., financial aid) to US citizens enrolled in US medical schools, as opposed to alien and US FMG's. (2) There should be guidelines to limit the number of FMG's entering the US for the purpose of graduate medical training as well as to practice medicine modified as appropriate in response to assessment of needs. Public policy toward extending the rights of foreign-trained physicians to practice in the US should be sensitive to the impact of the individual's practice on the health care delivery system. (3) Immigration legislation should allow adequate time to complete training. (4) Steps should be taken to aid developing countries in providing incentives for their physicians to return to or remain in their own country. (5) Determination of an individual's qualifications should include assessment of the individual student or medical school graduate as well as the foreign medical school attended. (6) Individuals contemplating a career in medicine should be informed of the requirements necessary to successfully enter the US medical profession as well as residency training programs' preference for graduates of US medical schools.
Whereas, Antipsychotic medications are frequently used in nursing homes as a means of chemical restraint, primarily in patients with dementia\textsuperscript{1-3} and

Whereas, The US Food and Drug Administration issued a public health advisory warning of fatal adverse events in patients with dementia treated with atypical antipsychotic drugs, and no drugs are currently FDA approved for this usage\textsuperscript{4}; and

Whereas, The adverse effects of antipsychotic medications on patients with dementia has been well studied\textsuperscript{5-9} and likely cause thousands of deaths per year\textsuperscript{10}; and

Whereas, A recent analysis of Pimavanserin, an atypical antipsychotic approved for Parkinson’s related psychosis but frequently used off label in nursing home residents, revealed over 2000 cases of adverse events including falls, insomnia, hallucinations, and 244 deaths between June 2016 and March 2017\textsuperscript{11}; and

Whereas, Interviews of nursing home residents and their families uncover immense subjective discomfort with antipsychotic prescribing practices and many have stories of how these drugs have negatively impacted their families\textsuperscript{3}; and

Whereas, The Beers criteria developed by the American Geriatrics Society strongly discourage the use of antipsychotics in patients with dementia\textsuperscript{12}; and

Whereas, In 2016, the American Psychiatric Association (APA) released guidelines on antipsychotic usage in patients with dementia that discourages their use in most situations\textsuperscript{13}; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) is not using its full authority to address multiple contributors to inappropriate usage of antipsychotics for dementia patients\textsuperscript{3}; and

Whereas, In some cases CMS regulations of antipsychotic usage in nursing homes has not been evidence based and have spurred criticism from the AMA, specialty societies, and state medical societies; and
Whereas, Recent studies have shown that nursing homes can reduce their usage of antipsychotics for patients with dementia with a variety of methods, including educational programs; and

Whereas, Surveys of nursing home staff show that they perceive important benefits of non-pharmacologic approaches and complain of barriers, such as lack of family education and insufficient support from clinicians; and be it further

RESOLVED, D-120.951: Appropriate Use of Antipsychotic Medications in Nursing Home Patients

Our AMA will meet with the Centers for Medicare & Medicaid Services (CMS) and representatives of other appropriate national medical specialty societies in order to educate CMS on distinguishing appropriate and inappropriate usage of antipsychotics in patients with dementia, with the goal of this meeting to support CMS efforts to curtail inappropriate usage, and ask CMS for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed and will to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis.

Fiscal Note: Significant, 12

Date Received: 04/11/18

RELEVANT AMA AND AMA-MSS POLICY

D-120.951: Appropriate Use of Antipsychotic Medications in Nursing Home Patients
Our AMA will meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed and will ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis.

H-25.989: Long-Term Care Prescribing of Atypical Antipsychotic Medications
Our AMA: (1) will collaborate with appropriate national medical specialty societies to create educational tools and programs to promote the broad and appropriate implementation of non-pharmacological techniques to manage behavioral and psychological symptoms of dementia in nursing home residents and the cautious use of medications; (2) supports efforts to provide additional research on other medications and non-drug alternatives to address behavioral problems and other issues with patients with dementia; and (3) opposes the proposed requirement that physicians who prescribe medications with "black box warnings on an off-label basis certify in writing that the drug meets the minimum criteria for coverage and reimbursement by virtue of being listed in at least one of the authorized drug compendia used by Medicare."

H-280.951: Quality of Care and Staffing in Nursing Homes
Our AMA will support the policy that staffing levels in nursing homes should appropriately address: (1) the acuity of the patient population; (2) the functional level of the patient and the services provided; (3) the existence of shortages for certain types of staff in some geographic locations and temporary shortages due to events such as employee illness or termination; and (4) the quality, education, and training of staff.

H-280.963: Drug Regimen Review in Long Term Care Settings
The AMA: (1) supports physician involvement in drug utilization review in long term care
settings and encourages CMS to recognize that the evaluation and management services of the medical director (MD/DO) of the long term care facility can reduce drug expenditures, fraud and overutilization while assuring quality medical care; (2) encourages CMS to conduct well-designed research into medication uses in nursing facilities and the clinical outcomes of drug therapy; and (3) will work closely with the American Medical Directors Association and other appropriate organizations to improve outcomes of drug therapy in nursing homes and to encourage CMS to review the issue of appropriate professional resources needed to provide optimal prescription use in nursing facilities.

H-25.999: Health Care for Older Patients
The AMA: (1) endorses and encourages further experimentation and application of home-centered programs of care for older patients and recommends further application of other new experiments in providing better health care, such as rehabilitation education services in nursing homes, chronic illness referral centers, and progressive patient care in hospitals; (2) recommends that there be increased emphasis at all levels of medical education on the new challenges being presented to physicians in health care of the older person, on the growing opportunities for effective use of health maintenance programs and restorative services with this age group, and on the importance of a total view of health, embracing social, psychological, economic, and vocational aspects; (3) encourages continued leadership and participation by the medical profession in community programs for seniors; and (4) will explore and advocate for policies that best improve access to, and the availability of, high quality geriatric care for older adults in the post-acute and long term care continuum.

280.001MSS: Quality of Nursing Homes
AMA-MSS will ask the AMA to express publicly its concern for inadequate nursing home care, advocate high standards for such care, and support efforts to establish adequate funding of nursing and convalescent homes that would allow them to maintain qualified personnel.
Whereas, in the aftermath of adverse weather events, physician response is essential to the short-term recovery efforts of a community;¹ and

Whereas, in the aftermath of Hurricane Harvey, local, state, and out-of-state physicians did not have guidelines for participation in refugee shelters;¹,⁵ and

Whereas, an estimated 25% of emergency room visits during Hurricane Katrina were for chronic disease treatment;²,⁷ and

Whereas, dialysis care is often disrupted during catastrophic weather events with a 21% increase in dialysis-related emergencies occurring during Hurricane Sandy,⁸ and dialysis patients struggled to receive necessary care during Hurricane Harvey;³,⁴,⁵,⁶,⁷,¹²,¹³ and

Whereas, a significant increase in number of diabetes-related patients, both acute and chronic, and patients with diabetes-related comorbidities presented to emergency departments during and after Hurricane Sandy;¹⁴,¹⁵ and

Whereas, an estimated 7% of emergency room visits during Hurricane Katrina were for prescription refills,2,6 and a shortage of prescription medications plagued emergency department visits for numerous diseases including tuberculosis, and respiratory illnesses during Hurricane Sandy;9 and

Whereas, the Texas Medical Center and Houston Methodist health system implemented a five-prong checklist in the wake of Tropical Storm Allison and in preparation for Harvey;12, 13 and

Whereas, improved flood gates and backup generators, a resilient culture, improved technology and communication, advanced stockpiling of food, medications, and supplies, and the development and drilling of emergency policies and procedures in preparation for the storm helped give people clearly defined roles and responsibilities and put in place procedures to ensure hospitals’ continuity of operations during Hurricane Harvey;12 and

Whereas, telehealth was used to care for patients after Hurricane Harvey and health systems like Nemours Children’s Health System have begun integrating remote care into their disaster plans;13 and

Whereas, in response to the hundreds of people without essential prescription medications after the Joplin, MO tornado due to the loss of residential and medical facilities, a state executive order allowed pharmacists to provide emergency medication to people whose medical records were missing or who no longer had a doctor’s prescription on hand;10 and

Whereas, before the tornado, Joplin health officials had developed a plan for simplifying healthcare delivery and reimbursement in emergency circumstances. This system enabled healthcare providers to continue to provide care when traditional systems were overwhelmed and ensured that responders were compensated in a timely manner;11 and

Whereas, The Missouri Department of Health and Senior Services tracked 713 individuals who were injured during the Joplin, MO tornado of 2011 and evacuated them to 42 hospitals and also provided care for dialysis and ventilator-dependent patients;11 and

Whereas, per the plan of Joplin healthcare officials, providers had previously instructed dialysis patients to create an emergency three-day care plan, which they were instructed to implement following the 2011 tornado;\(^{11}\) and

Whereas, providing medical care during Hurricane Harvey, Hurricane Sandy, and the Joplin Tornado demonstrate the necessity of advanced preparations to adequately provide medical care during a disaster;\(^{11,12,13}\) and

Whereas, lessons learned during Hurricane Harvey, Hurricane Sandy, and the Tornado in Joplin have provided clear evidence that individuals with chronic diseases are particularly vulnerable and healthcare providers must take additional steps to ensure proper continuity of care;\(^{1,2,3,4,5,6,7,8,9,10,11,12,13,14,15}\) therefore be it

RESOLVED, That our AMA amend current Policy H-130.942 by addition to read as follows:

Development of a Federal Public Health Disaster Intervention Team, H-130.942

1. Our AMA supports government efforts to: (a) coordinate and integrate federal medical and public health disaster response entities such as the Medical Reserve Corps, National Disaster Medical System, Public Health Services Commissioned Corps (PHSCC), as well as state-to-state sponsored Emergency Management Compact Systems, to strengthen health system infrastructure and surge capacity for catastrophic disasters (Incidents of National Significance) as defined by the Department of Homeland Security’s (DHS) National Response Plan (NRP); and (b) place all federal medical and public health disaster response assets (with the exception of the Department of Defense) under authority of the Secretary of the Department of Health and Human Services (DHHS) to prevent significant delays and ensure coordination during a catastrophic disaster (Incident of National Significance).

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2. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will work with the DHHS, PHSCC, DHS, and other relevant government agencies to provide comprehensive disaster education and training for all federal medical and public health employees and volunteers through the National Disaster Life Support and other appropriate programs. Such training should address the medical and mental health needs of all populations, including children, the elderly, and other vulnerable groups.

3. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will monitor progress in strengthening federal disaster medical and public health response capacity for deployment anywhere in the nation on short notice, and report back as appropriate.

4. Our AMA, identify variables that need to be accounted for during a disaster to ensure adequate continuity of care that include, but is not limited to, procuring vital prescription drugs, accounting for chronic disease management, establishing clinics in refugee shelters, populating clinics with local, state, and out-of-state physicians, determining organization of clinical workflow, the role of telemedicine, and utilizing EMR or paper medical records at temporary clinics.

Fiscal Note: Significant, 10

Date Received: 04/11/2018

RELEVANT AMA AND AMA-MSS POLICY
8.3 Physicians’ Responsibilities in Disaster Response & Preparedness

Whether at the national, regional, or local level, responses to disasters require extensive involvement from physicians individually and collectively. Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This obligation holds even in the face of greater than usual risks to physicians’ own safety, health, or life.

However, the physician workforce is not an unlimited resource. Therefore, when providing care in a disaster with its inherent dangers, physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future.

With respect to disaster, whether natural or manmade, individual physicians should:

(a) Take appropriate advance measures, including acquiring and maintaining appropriate knowledge and skills to ensure they are able to provide medical services when needed.

Collectively, physicians should:

(b) Provide medical expertise and work with others to develop public health policies that:

(i) are designed to improve the effectiveness and availability of medical services during a disaster;

(ii) are based on sound science;

(iii) are based on respect for patients.

(c) Advocate for and participate in ethically sound research to inform policy decisions.

Development of a Federal Public Health Disaster Intervention Team H-130.942

1. Our AMA supports government efforts to: (a) coordinate and integrate federal medical and public health disaster response entities such as the Medical Reserve Corps, National Disaster Medical System, Public Health Services Commissioned Corps (PHSCC), as well as state-to-state sponsored Emergency Management Compact Systems, to strengthen health system infrastructure and surge capacity for catastrophic disasters (Incidents of National Significance) as defined by the Department of Homeland Security’s (DHS) National Response Plan (NRP); and (b) place all federal medical and public health disaster response assets (with the exception of the Department of Defense) under authority of the Secretary of the Department of Health and Human Services (DHHS) to prevent significant delays and ensure coordination during a catastrophic disaster (Incident of National Significance).

2. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will work with the DHHS, PHSCC, DHS, and other relevant government agencies to provide comprehensive disaster education and training for all federal medical and public health employees and volunteers through the National Disaster Life Support and other appropriate programs. Such training should address the medical and mental health needs of all populations, including children, the elderly, and other vulnerable groups.

3. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will monitor progress in strengthening federal disaster medical and public health response capacity for deployment anywhere in the nation on short notice, and report back as appropriate.
Hospital Disaster Plans and Medical Staffs H-225.941
Our AMA encourages: (1) appropriate stakeholders to examine the barriers and facilitators that medical staffs will encounter following a natural or other disaster; and (2) hospitals to incorporate, within their hospital disaster plans, workplace and personal preparedness efforts that reduce barriers to staff responses during a natural or other disaster, both within their institutions and across the community.

Medical Care in Countries in Turmoil H-65.994
The AMA (1) supports the provision of food, medicine and medical equipment to noncombatants threatened by natural disaster or military conflict within their country through appropriate relief organizations; (2) expresses its concern about the disappearance of physicians, medical students and other health care professionals, with resulting inadequate care to the sick and injured of countries in turmoil; (3) urges appropriate organizations to transmit these concerns to the affected country's government; and (4) asks appropriate international health organizations to monitor the status of medical care, medical education and treatment of medical personnel in these countries, to inform the world health community of their findings, and to encourage efforts to ameliorate these problems.
WHEREAS, 3D printed devices are an emerging technology currently accounting for $524 million in medical spending internationally in 2015;¹ and

WHEREAS, Printed devices are already used for surgical guides, implants, and practice models specific to patient anatomical needs in various capacities among countries;¹⁻⁴ and

WHEREAS, Custom printed implants, while inherently different and a subject of continuous regulatory research, are generally held to the same standard of demonstration as non-printed implants by the Food and Drug Administration,¹ and

WHEREAS, The vast majority of surgical fields directly implementing patient-specific printed devices report significantly improved patient outcome, shorter surgery time, and reduced radiation exposure compared to standard practice;¹⁻² and

WHEREAS, A 2016 review indicates up to 21% of studies involving printed devices report a need for improved accuracy and 19% report a need for relative cost to be considered as a major factor,⁴ indicating a need for standardization; and

WHEREAS, As of 2017 there is no developed specific protocol or widely accepted standard for medical procedures implementing 3D printed implants or guides based on image-based modeling of patients;¹⁻² and

WHEREAS, printed implants generally carry the most risk (class III FDA designation) compared to other applications, and require conformation to internal organizing standards for biocompatibility, as well as laboratory and animal testing if a special exemption is not obtained;⁵ and

Whereas, there is no standard for final product quality assurance, finishing, or sterilization based on print material;\(^5\) and

Whereas, existing AMA or AMA-MSS policy encourages the study of biotechnologies based on long-term patient outcomes, costs, \((H-480.001, H-480.972, H-105.988)\) and potential impact on healthcare roles and relationships \((D-165.99)\), while promoting necessary education \((H-105.988, H-460.00)\); therefore be it

RESOLVED, that our AMA support research into the efficacy of patient-specific devices and models that are designed and printed, by or under physician supervision, and be it further

RESOLVED, that our AMA advocate for the education of physicians and the public about the availability and efficacy of 3D printed devices.

Fiscal Note: Significant, 12

Date Received: 04/11/18

**RELEVANT AMA AND AMA-MSS POLICY**

The Impact of Rapidly Developing Biotechnology on the Delivery of Medical Care \(D-165.999\)

(1) Our AMA Council on Medical Service will continue to study and report on the impact of technological developments on the practice of medicine, the patient-physician relationship, and the physician workforce. (2) Our AMA will accelerate efforts to implement its policy on individually owned and selected health expense coverage \((Policy \ H-165.920)\), and other policies that promote individual fiscal responsibility for consumption of medical care.

Medical Device Safety and Physician Responsibility \(H-480.972\)

The AMA supports: (1) the premise that medical device manufacturers are ultimately responsible for conducting the necessary testing, research and clinical investigation and scientifically proving the safety and efficacy of medical devices approved by the Food and Drug Administration; and (2) conclusive study and development of Center for Devices and Radiological Health/Office of Science and Technology recommendations regarding safety of device surveillance and other potentially harmful electronic devices with respect to pacemaker use.

Direct-to-Consumer Advertising \((DTCA)\) of Prescription Drugs and Implantable Devices \(H-105.988\)

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, our AMA opposes product-claim (DTCA) that does not satisfy the following guidelines:

(a) The advertisement should be indication-specific and enhance consumer education about 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-claim (DTCA) 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), 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.

3. That the FDA review and pre-approve all (DTCA) 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) 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).

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-claim (DTCA) and with the Council on Ethical and Judicial Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in that Opinion.

10. That the Congress should request the Agency for Healthcare Research and Quality 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).

14. Our AMA will advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer’s suggested retail price of those drugs.

Registry of Implantable Devices H-480.986

It is the policy of the AMA: (1) to support the concept of a computerized national tracking system for long-term implanted devices that pose a significant risk of serious harm or death to patients if they malfunction or fail completely; (2) that such a system include the communication of the potential for malfunction or failures to the attending surgeon or physician and from the physician to the patient; and (3) to work with all involved parties to satisfactorily address this issue.

Medical Technology Assessment H-480.001

AMA-MSS supports the following principles: (1) Medical technology assessment should include societal, economic, ethical, and legal consequences of medical technologies, as well as concerns of safety and efficacy. (2) The medical community should stress the use of randomized, controlled clinical trials when ethical prior to the widespread dissemination of medical technologies and emphasize the importance of clinical trials to health professionals. (3) Medical technologies should not be accepted as standard medical practice before they have
been adequately assessed with respect to their safety, efficacy, cost-effectiveness and societal consequences. (4) Organized medicine should continue its involvement with the Prospective Payment Assessment Commission, and should actively lobby for funding which would allow this body to accomplish its mandate with regard to medical technology evaluation. (5) Organized medicine should support the creation of a private/public sector consortium, as defined by the Institute of Medicine of the National Academy of Sciences, which would act as a clearinghouse for the evaluation of medical technologies. (6) Organized medicine should seek active representation in such a private/public sector consortium, and should research possible sources of funding (e.g., government, third party payers, technology producers). (7) Organized medicine should work to assure a mechanism for awarding competitive grants to fund high quality clinical trials for the assessment of medical technology. (MSS Position Paper 1, I-83) (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)

Biomedical Research & Research Training H-460.00

AMA-MSS will apply its existing policy of support for biomedical research and research training by (1) continuing its support of the established peer review system whereby research funds are granted and (2) opposing any attempts to increase direct congressional control over the specific allocation. (MSS Sub Res 10, A-84) (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)
Whereas, The average age of matriculating medical students is increasing\(^1\); and

Whereas, The increasing number of nontraditional medical students enhances medical school classes\(^2\); and

Whereas, Pregnancy during undergraduate medical education is becoming increasingly common\(^3\); and

Whereas, A lack of flexibility in medical school curriculum poses a significant detriment to medical students who are parents, particularly on their mental health\(^4,5\); and

Whereas, Physicians have been shown to feel pressure in choosing between their family and career, particularly regarding taking time off for parental duties\(^6,7,8\); and

Whereas, Conflict between work and family life has been linked to a greater degree of negative mental health outcomes in physicians\(^9\); and

\(^1\) "Applicants and Matriculants Data - FACTS: Applicants, Matriculants, Enrollment, Graduates, MD/PhD, and Residency Applicants Data - Data and Analysis - AAMC." Association of American Medical Colleges, www.aamc.org/data/facts/applicantmatriculant/


Whereas, Increased duration of parental leave improves parental mental health outcomes\textsuperscript{10,11,12}; 
Whereas, Parental leave decreases incidence of early childhood mortality and improves childhood health outcomes\textsuperscript{12,13,14,15}; therefore, be it, 

RESOLVED, That our AMA-MSS support extended leave for students and physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; and be it further 

RESOLVED, That our AMA-MSS encourages medical schools to create parental leave policies which clearly state how time can be made up in order for a medical student to graduate on time, what period of leave would result in a medical student being required to complete an extra or delayed year of training, and whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling; and be it further 

RESOLVED, That our AMA-MSS encourages medical schools, residency programs, specialty boards, and medical groups to incorporate policy that protects medical students and residents from unfair discrimination, evaluation and/or treatment by upper level staff members based on their necessity to take a leave of absence, in particular, parental leave usage; and be it further 

RESOLVED, That our AMA-MSS encourages flexibility in medical school rotations and residency training programs, incorporating parental leave and alternative schedules for pregnant house staff and students; and be it further 

RESOLVED, That our AMA-MSS encourages medical schools to assist students in developing alternate schedules that allow for students to receive adequate time off for leave that is amenable to the program's curriculum, while still being eligible to graduate on time. 

Fiscal Note: Significant, 10 

Date Received: 04/11/2018 

AMA Policy

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.

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this Residents and Fellows’ Bill of Rights.

4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution’s process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency
and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.

6. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENTS AND FELLOWS' BILL OF RIGHTS

Residents and fellows have a right to:
A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience, and that reflect cost of living differences based on geographical differences.
(3) With regard to benefits, residents and fellows should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care; b. Education on the signs of excessive fatigue, clinical depression, and substance abuse and dependence; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and paternity leave and educational leave during each year in their training program the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act.
F. Duty hours that protect patient safety and facilitate resident well-being and education.
With regard to duty hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with duty-hour requirements set forth by the ACGME or other relevant accrediting body; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that duty-hour requirements are effectively circumvented.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
Support for Residents and Fellows During Family and Medical Leave Time H-310.908
Our AMA encourages specialty boards, the Accreditation Council for Graduate Medical Education and residency review committees to study alternative mechanisms and pathways based on competency evaluation to ensure that individuals who have taken family and medical leave graduate as close to their original completion date as possible.

AMA Statement on Family and Medical Leave H-420.979
Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother;
(3) leave if medically appropriate to care for a member of the employee’s immediate family, i.e., a spouse or children; and
(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

AMA-MSS Policy:
310.049MSS Equal Paternal and Maternal Leave for Medical Residents
That our AMA amend policy H-405.960 by insertion and deletion as follows:
H-405.960 Policies for Maternity, Family and Medical Necessity Leave

AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity, Family and Medical Necessity Leave for Medical Students and Physicians: (1) The 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 written leave policies, including parental, family, and medical leave policies, as part of the physician’s standard benefit agreement; (2) Recommended components of maternity and paternity 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; and (j) leave policy for paternity. (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 maternity and paternity leave without the loss of status. (4) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their maternity and paternity leave policies a six-week minimum leave allowance, with the understanding that no woman or man 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 paternity leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice equal to maternity leave benefits; (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 maternity and paternity leave and alternative schedules for pregnant house staff; and (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; and (14) These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship. (CCB/CLRPD Rep. 4, A-13) (Modified: Res. 305, A-14) (MSS Res 36, A-14) (AMA Res 904, I-14 Adopted as Amended)
Whereas, The quantity of times a sperm donor can donate is unregulated in the United States; and

Whereas, Monetary compensation for donors motivates individual repeat sperm donation; and

Whereas, This leads to the problem of homozygosity and cases of consanguinity due to offspring not knowing who their siblings are; and

Whereas, Other countries limit the number of offspring that one donor can have. The number varies between countries and goes as low as five children in France or up to 25 children in the Netherlands, and

Whereas, In the US, the American Society for Reproductive Medicine (ASRM) has a guideline in place that recommends 25 births per population of 800,000; and

Whereas, This guideline is not enforced and given that the population of the USA is currently around 323 million that puts the current recommended cap per donor at 10,000 children; and

Whereas, Existing AMA policy calls for our AMA to support that "The number of pregnancies resulting from a single gamete donor is limited"; therefore be it

Resolved, That our AMA draft and advocate for legislation which limits the number of offspring that one sperm donor can have to 25.

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RELEVANT AMA AND AMA-MSS POLICY:

Gamete Donation: Code of Medical Ethics Opinion 4.2.2

Donating eggs or sperm for others to use in reproduction can enable individuals who would not otherwise be able to do so to have children. However, gamete donation also raises ethical concerns about the privacy of donors and the nature of relationships among donors and children born through use of their gametes by means of assisted reproductive technologies.

Physicians who participate in gamete retrieval and storage should:

(a) Inform prospective donors of sperm or ova:

1. About the clinical risks of gamete donation, including the near and long-term risks and the discomforts of ovarian hyperstimulation and egg retrieval as appropriate
2. About the need for full medical disclosure and that prospective donors will be tested for infectious disease agents and genetic disorders
3. Whether and how the donor will be informed if testing indicates the presence of infectious disease or genetic disorder
4. That all information collected, including test results, will be stored indefinitely
5. What additional personal information will be collected about the donor
6. Under what circumstances and with whom personal information, including identifying information, will be shared for clinical purposes
7. How donated gametes will be stored and policies and procedures governing the use of stored gametes
8. Whether and how the donor will be compensated
9. The fact that state law will govern the relationship between the donor and any resulting child (or children)

(b) Exclude prospective donors for whom testing reveals the presence of infectious disease agents.

(c) Obtain the prospective donor’s consent for gamete retrieval.

(d) Discuss, document and respect the prospective donor’s preferences for how gametes may be used, including whether they may be donated for research purposes.

(e) Discuss, document, and respect the prospective donor’s preferences regarding release of identifying information to any child (or children) resulting from use of the donated gametes.

(f) Adhere to good clinical practices, including ensuring that identifying information is maintained indefinitely so that:

10. Donors can be notified in the event a child born through use of his/her gametes subsequently tests positive for infectious disease or genetic disorder that may have been transmitted by the donor.
11. The number of pregnancies resulting from a single gamete donor is limited.
Whereas, Virtual reality (VR) is a computer-generated scenario that simulates a realistic experience; and

Whereas, Augmented reality (AR) is a direct or indirect live view of a physical, real-world environment whose elements are "augmented" by computer-generated perceptual information, ideally across multiple sensory modalities, including visual, auditory, haptic, somatosensory, and olfactory; and

Whereas, VR/AR technologies provide realistic simulations to assist planning and implementation of surgical procedures\(^1\) and imaging studies\(^2,3\), allowing better prediction of patient outcomes\(^4\); and

Whereas, the application of these technologies has shown potential in reducing symptoms of psychiatric disorders in children and adolescents\(^5\), improving dynamic balance for older


individuals with self-reported balance problems\(^6\), and providing accurate estimation of food serving sizes with profound public health implications\(^7\); and

Whereas, The gamification of healthcare that comes with these technologies has been found to increase patient immersion and engagement in their own health by incorporating playfulness, entertainment, and competition into their health routines\(^8\); and

Whereas, VR/AR technologies are poised to be a critical tool for doctors and medical students to extend the range of scenarios they can experience in training\(^9,10\), particularly in surgery\(^11\) and emergency medicine\(^12\); and

Whereas, These technologies require specialized training to understand their value and limitations with respect to learning healthcare delivery; and

Whereas, Partnerships with technology companies already exist in medical school environments\(^13\), thus providing a basis for expanded training programs in emerging technologies; and

Whereas, VR/AR technologies can complement cadaveric anatomy teaching, allowing medical students to bypass the financial, ethical, and supervisory constraints associated with the use of cadavers through digital anatomy simulations\(^14\); and

Whereas, AMA policy (H-295.995) states that students should be educated in an increased breadth of clinical knowledge and the AMA MSS (295.044MSS) recognizes the future of medicine as an important educational goal for medical students; therefore be it

RESOLVED, That our AMA encourages medical schools to evaluate and update as appropriate their curriculum to increase students’ exposure to VR/AR technologies, in particular with regards to anatomy instructions, surgical and procedural trainings, and emergency medicine simulations, and be it further


RESOLVED, That our AMA encourages medical schools to provide student access to VR/AR research opportunities and resources, including VR gear and software development platforms, and be it further

RESOLVED, That our AMA encourages medical students to attend VR/AR conferences and interact with students in engineering, computer science, and other related fields, and be it further

RESOLVED, That our AMA encourages student involvement in clinical trials evaluating the effects of VR/AR on patient care, with particular emphasis on patients with special needs including older individuals and those with psychiatric disorders, and be it further

RESOLVED, That our AMA encourages medical students to engage in discussions about ethical issues regarding the use of VR/AR technologies in patient care and public health studies, especially with respect to the implications for patient privacy rights.
RELEVANT AMA AND AMA-MSS POLICY:

Recommendations for Future Directions for Medical Education H-295.995

Our AMA supports the following recommendations relating to the future directions for medical education: (1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty. (2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable. (3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals. (4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students. (5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician. (6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling. (7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication. (8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose. (9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions. (10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs. (11) Faculties should continue to evaluate curricula periodically as a means of ensuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine. (12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other
health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted. (13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student. (14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students. (15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged. (16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice. (17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education. (18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school. (19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For Physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines. (20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for
programs in graduate medical education. (21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs. (22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care. (23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public. (24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates. (25) Specialty boards should consider having members of the public participate in appropriate board activities. (26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities. (27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education. (28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued. (29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported. (30) U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various jurisdictions, prerequisites for entry into graduate medical education programs, and other factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME. (31) Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine. (32) Methods currently being used to evaluate the readiness of graduates of
foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital. (33) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems. (34) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels. (35) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education. (36) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance. (37) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.

Effective Education for the Future of Medicine 295.044MSS

Effective Education for the Future of Medicine: The AMA-MSS Governing Council will continue to identify opportunities to present timely and relevant health policy information to medical students.

Support of Business of Medicine Education for Medical Students 295.115MSS

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.

Educating Medical Students about the Pharmaceutical Industry 295.130MSS

AMA-MSS will ask the AMA to: (1) strongly encourage medical schools to include unbiased curricula concerning the impact of direct-to-consumer marketing practice employed by the pharmaceutical industry, as they relate to the physician-patient relationship; and (2) strongly encourage medical schools to include unbiased information in their curricula concerning the pharmaceutical industry regarding (a) the cost of research and development for new medications, (b) the cost of promoting and advertising new medications, and (c) the proportion of (a) and (b) in comparison to their overall expenditures, and (d) the basic principles in the decision-making process involved in prescribing medications specifically using evidence-based medicine to compare outcomes and cost effectiveness of generic versus proprietary medications of the same class. (MSS Sub Res 15, I-04) (AMA Res 303, A-05 Adopted [D-
Update on the Uses of Simulation in Medical Education D-295.330

Our AMA will:

1. continue to advocate for additional funding for research in curriculum development, pedagogy, and outcomes to further assess the effectiveness of simulation and to implement effective approaches to the use of simulation in both teaching and assessment;

2. continue to work with and review, at five-year intervals, the accreditation requirements of the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the Accreditation Council for Continuing Medical Education (ACCME) to assure that program requirements reflect appropriate use and assessment of simulation in education programs;

3. encourage medical education institutions that do not have accessible resources for simulation-based teaching to use the resources available at off-site simulation centers, such as online simulated assessment tools and simulated program development assistance;

4. monitor the use of simulation in high-stakes examinations administered for licensure and certification as the use of new simulation technology expands;

5. further evaluate the appropriate use of simulation in interprofessional education and clinical team building; and

6. work with the LCME, the ACGME, and other stakeholder organizations and institutions to further identify appropriate uses for simulation resources in the medical curriculum.

Guidelines for Mobile Medical Applications and Devices D-480.972

1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.

2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.

3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence-based.
4. Our AMA will develop and publically disseminate a list of best practices guiding the development and use of mobile medical applications.

5. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows.

6. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training.

7. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments.

Physician Reentry D-300.984

Our AMA: 1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs.

2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice.

3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics.

4. Will support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs.

5. Will make available to all interested parties the physician reentry program (PREP) system Guiding Principles for use as a basis for all reentry programs: a. Accessible: The PREP system is accessible by geography, time and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions or the health care system. b. Collaborative: The PREP system is designed to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across
specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible. c. Comprehensive: The PREP system is comprehensive to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice. d. Ethical: The PREP system is based on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statues. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed. e. Flexible: The PREP system is flexible in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians. f. Modular: Physician reentry programs are modularized, individualized and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need. g. Innovative: Innovation is built into a PREP system allowing programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation. h. Accountable: The PREP system has mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician’s competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of the measures are established. Standardization of measures exist across programs to assess whether or not national standards are being met. i. Stable: A funding scheme is in place to ensure the PREP system is financially stable over the long-term. Adequate funding allows physician reentry programs to operate at sufficient and appropriate capacity. j. Responsive: The PREP system makes refinements, updates and other changes when necessary. Physician reentry programs are equipped to address systemic changes such as changes in regulations. Additionally, the PREP system is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster.

6. Our AMA encourages each state which does not grant a full and unrestricted license to physicians undergoing reentry to develop a non-disciplinary category of licensure for physicians during their reentry process.

Nanotechnology, Safety and Regulation H-480.949

Our AMA: (1) recognizes the benefits and potential risks of nanotechnology; (2) supports responsible regulation of nanomaterial products and applications to protect the public's health and the environment; and (3) encourages continued study on the health and environmental effects of exposure to nanomaterials.
The Precision Medicine Initiative D-460.968

1. Our AMA will 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. Our AMA encourages 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. Our AMA continues 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.
INTRODUCTION

After the 2017 Interim Meeting of the American Medical Association Medical Student Section (AMA-MSS), the AMA-MSS Governing Council (GC) convened a MSS Resolution Process Task Force to make recommendations to strengthen the current resolution process.

The charge to the MSS Resolution Process Task Force (RTF) was to assess the effectiveness of our current resolution process in achieving its goals, to collect and evaluate information on the impact of our current process on the various stakeholders in our process, and to recommend actions and efforts that would have a meaningful positive impact on the major resolution process concerns:

a. Insufficient time for adequate discussion of resolutions in the Assembly
b. Impact on student leadership (including sectional and regional delegates as well as the MSS House of Delegates Coordinating Committee)
c. Impact on AMA staff (including MSS staff and non-MSS experts)
d. Number of external resolutions forwarded to House of Delegates (HOD)

The RTF produced MSS RTF Report 1-A-18, containing recommendations for resolution process reforms that the RTF believes will encourage mentorship within the MSS, protect the democratic opportunity to be heard, foster high-quality discussion in the MSS Assembly, and preserve resources for the advocacy of MSS-originated resolutions in the AMA House of Delegates (HOD). The RTF recommended that the MSS GC consider its proposed reforms to the resolution process and release a GC Report to the Assembly detailing a pilot implementation of the reforms.

The MSS GC conducted a review of recommendations proposed by the RTF within MSS RTF Report 1-A-18. Based on the Task Force’s recommendations, the MSS GC has outlined in this report a pilot process to be implemented during the next cycle of the resolution process for the 2018 MSS Interim Meeting and HOD Interim Meeting.

PILOT RESOLUTION PROCESS

Your GC recommends the implementation of a pilot based on the following reforms during the next cycle of the resolution process, and that the remainder of the report be filed. Following the pilot, the MSS GC will produce a GC report to the Assembly for the 2019 Annual Meeting proposing changes to the MSS resolution process through amendments to the MSS Internal Operating Procedures.

1. That the MSS invest in further education efforts on the resolution process by:
a. Training RD/ADs to provide better guidance on the various mechanisms available for advocacy through the AMA and MSS.
b. Making a video explaining the basics of Parliamentary Procedure and the most common mistakes made.

2. That the MSS elevate the stature of non-resolution avenues for advocacy by:
   a. Clarifying what makes a successful GC Action Item, publicizing GC Action Item Requests widely, and increasing the prestige of these proposals.
   b. Creating a new, informational category of business for the Assembly, which would be presented by authors in a separate programming session at the meeting. The process for accepting and reviewing submissions for this category of business and executing this session will be directed by MSS Standing Committees and the MSS GC Vice Chair.
   c. Providing a formal document to its members as proof of significant, non-resolution-related work, which they can provide as support for a conference funding and time-off request. Examples of significant, non-resolution-related work include serving as a Delegate or on a Committee.

3. That the MSS encourage mentorship between its members and throughout the AMA by:
   a. Creating a voluntary indicator on the Open Forum and during the resolution draft phase that shows if the originator is a first-time author. This visibility would allow more experienced writers to help new authors and mentor them through the process.
   b. Requiring all external resolution authors to contact the relevant specialty society prior to submission.

4. That the MSS improve transparency of resolution feedback among all actors throughout the resolution process by:
   a. Tasking the Government Relations Advocacy Fellow and Section Delegates with analyzing the Open Forum and resolution drafts for resolutions that the AMA Federal Advocacy Office would be interested in reviewing. These roles are noted by the MSS GC to have an appropriate level of understanding of what would be suitable for review by the Federal Advocacy Office.
   b. Broadening the functional scope of the House of Delegates Coordinating Committee (HCC) so HCC members can contact Region leaders to improve resolutions that would otherwise likely be reaffirmed.
   c. Requiring primary reviewers to send feedback summary emails to the primary author’s Region Chair and Region Delegation Chair in order to allow Regions to incorporate draft feedback into their Region authorship voting if they choose to.
   d. Requesting that HCC post a summary of their comments from the draft review process to the VRC.
   e. Requesting that RD/ADs provide meaningful testimony on the VRC for resolutions they reviewed, especially in cases where important recommendations from feedback provided to authors were not considered.

5. That the MSS streamline existing procedures in the resolution process by:
   a. Coordinating Region resolution authorship/support through a central AMA email process so more medical school sections can be reached.
   b. Giving HCC responsibility to review all submissions and place items on a Reaffirmation Consent Calendar. Items on the Reaffirmation Consent Calendar will not receive detailed staff review except analysis from Legal Counsel.
   c. Adjusting resolution deadlines to allow more time for review between the final submission and VRC.
6. That the MSS change its scoring rubric to:
   a. Reaffirm its existing rubric categories of authorship, clarity, research quality, scope, feasibility, novelty, addressing the MSS Policy Objectives and AMA Strategic Focus Areas, thoughtful response to feedback, and scoring on a quantitative scale.
   b. For external resolutions, increase the scoring weight of addressing the MSS Policy Objectives over that of addressing the AMA Strategic Focus Areas, as a way to promote Section objectives.
   c. Include scoring of the fiscal note as a consideration for feasibility, instead of as a separate rubric category.

7. That the MSS reaffirm its existing process of creating the Assembly’s Order of Business according to quantitative resolution scores.

8. That the MSS create and further opportunities for high-quality discussion in the Assembly by:
   a. The MSS Reference Committee noting in its rationale whether resolutions are suitable for a GC Action item. GC Action items may be submitted by the originating author or by individual members of the Section.
   b. Prioritizing Assembly time so that resolutions above a certain threshold receive protected time for debate, with the remaining time divided between resolutions below the threshold. Determination of this threshold shall be based on consideration of the amount of time needed to discuss a resolution and the amount of Assembly time available. To aid in this determination for I-18, GC will collect data at A-18 on how much time is spent discussing each resolution.

9. That the MSS improve continuity of its advocacy efforts from meeting to meeting by:
   a. Requiring authors of external resolutions to sign a virtual acknowledgement agreeing to help the Section Delegates and Regional Delegates in bringing their resolution to the AMA HOD if their resolution is passed by the Assembly.
   b. Tracking the outcome of MSS-initiated external resolutions that have had influence or impact. An example of influence or impact is action taken or statements made by the AMA Board of Trustees. These outcomes can be recorded by the MSS GC and shared with the Section membership.
   c. Giving the MSS GC responsibility for conducting an annual survey that sets the MSS Policy Objectives for the given year.
REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON LONG RANGE PLANNING

MSS COLRP Report A
A-18

Subject: Study of the Motivations Behind Resolution Writing

Presented by: MSS Committee on Long Range Planning
J. Steven Ekman, Chair; Lauren Engel, Vice Chair

Referred to: MSS Reference Committee
(----,Chair)

INTRODUCTION

At the 2017 Interim Meeting, the AMA-MSS Assembly adopted as amended Resolution 02, “Systematic Review of AMA-MSS Authored Resolutions in the AMA House of Delegates,” which states the following:

RESOLVED, That our AMA-MSS study the outcomes of MSS resolutions the AMA House of Delegates including both objective measures of resolution adoption rates as well as subjective measures to which MSS goals were met regardless of outcome; and be it further

RESOLVED, That our AMA-MSS Governing Council, under the direction of the Delegate and Alternate Delegate use the results of the study to continue to improve and update the resolution writing process and report back to the MSS Assembly at intervals deemed appropriate by the AMA-MSS Governing Council.

Accordingly, your Governing Council (GC) tasked your MSS Committee on Long Range Planning (COLRP) to study the motivations behind resolution writing. To accomplish this directive, your COLRP collaborated to write and execute a survey to collect data on students’ thoughts and experiences with the resolution process. This report begins with a description of the methodology used in the study. It then analyzes the data collected from student respondents. Commentary is provided with the individual charts and tables, and results are summarized in the discussion section. It concludes with the conclusions and recommendations derived from the data analyzed.

METHODS

The survey consisted of 18 questions in various formats including multiple choice, ranking, and free-response. The survey opened for responses on February 26th and closed on March 17th, 2018. To achieve a wide distribution of data, the survey was posted publicly on the MSS Succeeding in Medical School Community twice, shared with Region leaders and Region Facebook pages, and was directly sent to authors from A-17 and I-17, and the MSS Delegation, reaching upward of 300 students.
RESULTS

Respondent Demographics:

A total of 94 students responded to this survey from across all seven Regions. The outliers are R3 and R4. Despite multiple attempts, more responses could not be elicited.

Students were asked to indicate their state as well. The most common states were California (13), Michigan (11), Ohio (10), and Wisconsin (8). The remaining respondents were evenly scattered across 22 other states - Alabama, Arizona, Colorado, Connecticut, Georgia, Illinois, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nevada, New Jersey, New York, Pennsylvania, South Carolina, South Dakota, Tennessee, and Texas.
A majority of the respondents are second year medical students. The rest of the submissions were fairly evenly spread across the remainder of the medical school years. For the individuals who selected ‘Other,’ five are completing a PhD, three are completing a research year, and one is working in health policy after completing a graduate degree.
How many National AMA-MSS Meetings have you attended?

Number of Meetings Attended by Respondents

<table>
<thead>
<tr>
<th>Meetings</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Respondents</td>
<td>12</td>
<td>16</td>
<td>24</td>
<td>15</td>
<td>4</td>
<td>3</td>
<td>8</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

More respondents have attended two National AMA-MSS meetings than any other number. Roughly 25% of respondents have attended more than three meetings, with roughly 14% having attended zero meetings.

How many resolutions have you been listed as an author on throughout your involvement in the AMA-MSS?

Number of Resolutions Authored by Respondents
<table>
<thead>
<tr>
<th>Number of Resolutions</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>1 - 2</td>
<td>27</td>
</tr>
<tr>
<td>3 - 4</td>
<td>23</td>
</tr>
<tr>
<td>5 - 6</td>
<td>6</td>
</tr>
<tr>
<td>7 - 8</td>
<td>8</td>
</tr>
<tr>
<td>9 - 10</td>
<td>2</td>
</tr>
<tr>
<td>Greater than 10</td>
<td>3</td>
</tr>
</tbody>
</table>

1 More respondents have been listed as an author on 1-2 resolutions than any other number.
2 Only 20% of students have authored more than 4 resolutions.
3 Please select the most recent meeting at which you've authored a resolution.

### Most Recent Authorship by Meeting

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-17</td>
<td>41</td>
</tr>
<tr>
<td>A-17</td>
<td>17</td>
</tr>
<tr>
<td>I-16</td>
<td>5</td>
</tr>
<tr>
<td>A-16</td>
<td>0</td>
</tr>
<tr>
<td>I-15</td>
<td>0</td>
</tr>
<tr>
<td>A-15</td>
<td>0</td>
</tr>
<tr>
<td>Prior to A-15</td>
<td>0</td>
</tr>
</tbody>
</table>
The majority of respondents most recently authored a resolution at I-17. Only 35% of respondents most recently authored a resolution prior to I-17. All respondents have at least authored a resolution as recently at I-16.

Which of the following roles have you played with regards to resolution writing? Please select all that apply.

<table>
<thead>
<tr>
<th>Role</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Author</td>
<td>56</td>
</tr>
<tr>
<td>Contributing Author</td>
<td>44</td>
</tr>
<tr>
<td>Originated the idea for a resolution</td>
<td>42</td>
</tr>
<tr>
<td>Background research</td>
<td>49</td>
</tr>
<tr>
<td>Solicited student co-authors for a resolution (outside of the Open Forum post)</td>
<td>36</td>
</tr>
<tr>
<td>Reached out to outside sections/societies for information or support</td>
<td>34</td>
</tr>
<tr>
<td>Editing the resolution in response to feedback from RDs/ADs</td>
<td>47</td>
</tr>
</tbody>
</table>
The most common roles the respondents held were primary author, performing background research, and editing the resolution in response to feedback. Many respondents also originated resolution ideas and contributed to other resolutions as an author. Only a third of respondents actively sought out collaboration through recruiting other students or reaching out to other sections for information or support.

Which resources did you use to assist in your resolution development process? Please select all that apply.

Resources Used by Respondents

<table>
<thead>
<tr>
<th>Resource</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSS Policy Digest</td>
<td>43</td>
</tr>
<tr>
<td>MSS Summary of Actions</td>
<td>32</td>
</tr>
<tr>
<td>AMA PolicyFinder</td>
<td>58</td>
</tr>
<tr>
<td>MSS Resolution Writing Guide</td>
<td>50</td>
</tr>
<tr>
<td>Region-specific resolution writing materials</td>
<td>22</td>
</tr>
<tr>
<td>MSS Internal Operating Procedures</td>
<td>9</td>
</tr>
<tr>
<td>AMA Constitution &amp; Bylaws</td>
<td>10</td>
</tr>
<tr>
<td>Reached out to other MSS members</td>
<td>50</td>
</tr>
</tbody>
</table>
Reached out to MSS leadership (GC, Councilors, member on the Board of Trustees) 27

Reached out to state society 19

Reached out to specialty society 23

Other 1

In writing resolutions, students are most likely to access the AMA PolicyFinder and the MSS Resolution Writing Guide, and to reach out to other medical students. Very few members are accessing Region-specific materials even though multiple Regions maintain materials to supplement what is provided by the MSS Governing Council and MSS Staff. Authors are also not reaching out to state societies or specialty societies for support. The ‘other’ category listed PubMed as a resource.

Are the majority of resolutions that you have submitted Internal or External?

<table>
<thead>
<tr>
<th>Resolution Status</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal</td>
<td>19</td>
</tr>
<tr>
<td>External</td>
<td>32</td>
</tr>
<tr>
<td>Even mix</td>
<td>13</td>
</tr>
</tbody>
</table>

Internal resolutions are intended to shape MSS policy only. Once they are heard and passed through the MSS Assembly, these resolutions are added to the MSS policy digest but are not forwarded to the AMA House of Delegates (HOD). External resolutions are those resolutions that are passed by the MSS assembly and added to the MSS policy digest, but are intended to change or enact policy at the AMA HOD. After being passed in the MSS Assembly, they are submitted to the AMA House of Delegates by the MSS Delegate and Alternate Delegate on behalf of the Medical Student Section). Students surveyed are more likely to be submitting
Please rank in order of importance (#1 being most important) the following reasons to write a resolution by dragging and dropping each choice:

I wanted the AMA to take action on an issue.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>42</td>
</tr>
<tr>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>0</td>
</tr>
</tbody>
</table>

I wanted to fill a gap in AMA or MSS policy.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>28</td>
</tr>
<tr>
<td>3</td>
<td>24</td>
</tr>
<tr>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>0</td>
</tr>
</tbody>
</table>
I wanted to raise awareness of a specific issue and stimulate conversation about that issue.

My resolution topic is in my desired specialty area.
My resolution topic is related to my research.

I wanted to receive funding to attend a national MSS meeting.
I wanted to add publications to my resume/CV.

I wanted to improve my residency application.
Other motivations included resolution ideas that were directly related to patient experiences or involvement in community service, the topic was extremely important to the author and the author specifically wanted national policy changes.

The top three most important reasons identified for writing resolutions include a desire for AMA to take specific action on an issue, fill a policy gap, or to raise awareness and stimulate
conversation on a specific topic. This is reflected in question 17 when respondents were asked to state why they wrote a resolution over another advocacy route.

The lowest ranking reasons (excluding “other”) were resolution topics related to the authors’ research, receiving funding for a national meeting, and the desire to participate in an activity with peers.

**Have you ever received funding to attend a national meeting?**

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>70</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
</tr>
</tbody>
</table>
What requirements did you have to fulfill to receive funding? Please select all that apply.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>No requirements</td>
<td>13</td>
</tr>
<tr>
<td>Be a first author on an MSS resolution</td>
<td>8</td>
</tr>
<tr>
<td>Be an author on an MSS resolution</td>
<td>15</td>
</tr>
<tr>
<td>Online participation in the resolution process, e.g. Virtual Reference Committee posting</td>
<td>4</td>
</tr>
<tr>
<td>In-person participation in the resolution process, e.g. Assembly testimony</td>
<td>7</td>
</tr>
<tr>
<td>Service as a MSS Chapter Delegate/Alternate Delegate</td>
<td>26</td>
</tr>
<tr>
<td>Participation in a national standing committee</td>
<td>4</td>
</tr>
<tr>
<td>Leadership in a national standing committee</td>
<td>2</td>
</tr>
<tr>
<td>Activity</td>
<td>Count</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Participation in a national convention committee</td>
<td>4</td>
</tr>
<tr>
<td>Leadership in a national convention committee</td>
<td>2</td>
</tr>
<tr>
<td>Presenting MSS programming</td>
<td>8</td>
</tr>
<tr>
<td>Presenting a research poster</td>
<td>18</td>
</tr>
<tr>
<td>Participation in the AMA House of Delegates</td>
<td>16</td>
</tr>
<tr>
<td>Service as a MSS Regional Delegate/Alternate Delegate</td>
<td>13</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

Most respondents receive funding for attending. The most common requirement for funding is serving as a Delegate or Alternate Delegate for a school chapter. Other common requirements included presenting research, serving as a Region Delegate or Alternate Delegate and serving in the House of Delegates, and authoring a resolution in the MSS Assembly. In the ‘Other’ category, responses included participating in resolution review, submitting a report at the conclusion of the meeting, and also attending a meeting for the first time. One student also specifically noted that some chapters limit funding to a number of people and chapters will prioritize based upon authors and candidates running for positions. Another respondent also noted that all of these reasons may be required, but are not sufficient to secure funding for a meeting.
Rate the importance of participating in the resolution writing process to your overall AMA-MSS experience.

<table>
<thead>
<tr>
<th>Rank of Importance</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Important</td>
<td>45</td>
</tr>
<tr>
<td>Fairly Important</td>
<td>16</td>
</tr>
<tr>
<td>Important</td>
<td>4</td>
</tr>
<tr>
<td>Somewhat Important</td>
<td>2</td>
</tr>
<tr>
<td>Not Important</td>
<td>4</td>
</tr>
</tbody>
</table>

Overall, resolution writing is ranked high in importance to the majority of survey respondents. It should be noted, however, that selection bias may play a role in this response as many resolution authors and Regional Delegates and Alternate Delegates were asked to complete this survey.
Are you familiar with the following alternative options for advocacy? - Select one of the following:

Awareness and Usage of Alternative Advocacy Options

<table>
<thead>
<tr>
<th>Alternative Option</th>
<th>I have used this option</th>
<th>I have heard about this option</th>
<th>I do not know about this option</th>
</tr>
</thead>
<tbody>
<tr>
<td>GC Action Item</td>
<td>1</td>
<td>54</td>
<td>16</td>
</tr>
<tr>
<td>Reaching out to the MSS member on the AMA Board of Trustees</td>
<td></td>
<td>15</td>
<td>42</td>
</tr>
<tr>
<td>Working with MSS Standing Committees</td>
<td>22</td>
<td>39</td>
<td>9</td>
</tr>
<tr>
<td>Working with state and county medical societies</td>
<td>41</td>
<td>26</td>
<td>3</td>
</tr>
<tr>
<td>Working with the administration or other leaders at your school</td>
<td>30</td>
<td>37</td>
<td>3</td>
</tr>
<tr>
<td>Working with specialty societies</td>
<td>14</td>
<td>49</td>
<td>7</td>
</tr>
</tbody>
</table>
The greater percentage of respondents are aware of the alternative options for advocacy. The fewest number of respondents have utilized GC Action Items, working with specialty societies, and reaching out to the MSS member on the AMA Board of Trustees. The most commonly used alternative is working with state and county medical societies.

**Have you ever used one of the options above instead of submitting a resolution to the MSS Assembly?**

![Chart showing respondents who used an alternative option for advocacy over writing a resolution.](chart)

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>41</td>
</tr>
<tr>
<td>No</td>
<td>29</td>
</tr>
</tbody>
</table>

Over 50% of the respondents have used an alternative option for advocacy instead of submitting a resolution to the MSS Assembly.

**What was your primary reason for submitting a resolution to the AMA-MSS Assembly as opposed to an alternative advocacy option (as listed previously)?**

Out of the 50 responses that were provided for this question in the category of “a personal reason not listed above”, a few recurring themes emerged. Of those, 16 identified that the primary reason for submitting a resolution was to fill a specific policy gap in AMA or AMA-MSS policy. Students were primarily looking to add novel ideas to our policy digest or want to update the AMA's stance on time-sensitive issues. Additionally, 12 responses indicated that they wanted specific action at the level of lobbying or health policy by the AMA. Students in this organization specifically want to be part of the policy-making process, which the easiest route is by writing resolutions. They are satisfied when their ideas and goals can be visibly acted on at a national level.

Further, 11 responses indicated they wrote resolution to increase their involvement in the AMA-MSS and to stimulate conversation on topics. Students enjoy collaborating with students, both in their Region and without. The camaraderie that is established through engaging in health policy discussions is valued by AMA-MSS members. Additionally, students receive feedback from this
process, which is extremely helpful in developing ideas and contributes to their knowledge of
health policy as a whole.

Finally, 7 responses indicated that resolution writing seemed to be the most direct or best
avenue to accomplishing their goal. Students are not sure of what guarantee exists that their
ideas will be acted on if there is not concrete policy on the topics they are passionate about.
Many of these responses also indicated that the other avenues of policy are not well-known or
talked about, especially since the Assembly is the primary focus of our national meetings.
Students are also unsure as to how their ideas would fit into an alternative route.

Other feedback regarding the resolution writing process for the AMA-MSS:

There were several common themes among the freeform feedback responses provided at the
end of the survey regarding the overall resolution writing process for the AMA-MSS. The most
recurrent topic was that of mentorship. Of the 15 responses, 4 were related to mentorship.
Students commented that mentorship during the resolution writing process would be valuable in
improving the quality of and support for resolutions. Specific possibilities for mentors that were
mentioned include: veteran authors from within the MSS; region leaders; members of the RFS,
YPS, and other AMA sections; and practicing physicians with interest/expertise in the area of
the resolution. One student mentioned that check-ins with such mentors should be a required
part of the process for new authors. Another student commented it would be most beneficial to
have such mentorship early on in the process as once authors have already dedicated a lot of
time to their idea, they may be less willing to accept feedback suggesting alternative ways to
achieve their goal.

Another recurring theme (3 students) was that of resolution deadlines. A concern was raised
that the timeline for the resolution writing process is very short with little time in between
deadlines. Given the busy schedules of medical students, this has been a challenge for
students looking to submit quality resolutions. One student also suggested that the deadlines be
released as early and on as many platforms as possible.

In addition, students also made the following suggestions. Resolutions should only be written if
the intention is for some kind of action to be taken or change to be made. The availability of
alternative advocacy options should be further publicized. There should be a maximum number
of resolutions for a primary author per conference.

One student commented that their resolution had been referred for study and has not heard
back anything regarding its current status. They noted that the process seems nebulous and
has led to frustration.

DISCUSSION

The majority of respondents had greater than one year of experience in the AMA-MSS and have
attended at least one meeting, showing dedication to being involved in health policy. The
variation in the number of resolutions authored, especially with 22 respondents never authoring
before, provided a variety of perspectives to the responses to the questions in the survey.

Demographics:
94 students responded to the survey, spanning all seven regions. R3 and R4 were outliers, with
5 (5.31%) and 6 (6.38%) responses respectively, as was R5 with 22 responses (23.40%). The
response geography was varied, with the most common states replying to the survey being
California (13), Michigan (11), Ohio (10), and Wisconsin (8). 44.68% of the respondents were
second year medical students.
On the whole, the AMA-MSS seems to have a younger (new to AMA) demographic, as the majority of respondents (58.42%; 52/89) have attended two or fewer national meetings. Of note, 13.48% of respondents have never attended a national meeting (12/89), indicating a potential gap in connecting with our members. So much networking and communication occurs at MSS national meetings; therefore, not attending a national meeting could eventually cause a member to become increasingly disengaged. This offers the opportunity for involvement and investment in members between national meetings. Once invested in the AMA-MSS, however, many members stay involved in AMA-MSS, with 41.57% of respondents having been to 3 or more national meetings.

The majority of students (63.68%) ranked their involvement in writing resolutions as very important to their AMA-MSS experience. Most respondents had authored four or fewer resolutions, with roughly even distributions between not having written a resolution (24.17%), 29.67% having written 1-2 resolutions, and 25.27% having written between 3-4 resolutions.

As expected, the majority of resolutions were written for I-17 (65.07%) and A-17 (26.98%). Interaction with the resolution process varied; most commonly, the respondent was the primary author, performing background research, or editing the resolution in response to the RD/AD. Notably, only roughly one third of respondents (34/91; 37.36%) stated that that they had reached out to specialty societies or outside sections for information or support. This appears to be an underutilization of these very qualified resources, indicating a potential gap in MSS-member knowledge regarding the resolution research/support process.

Most authors utilize the AMA PolicyFinder, MSS Resolution Writing Guide, and collaboration with other MSS members as primary means of aiding resolution development. 50% of respondents submitted mainly external resolutions, noting they wanted AMA to take action on an issue, fill a gap in existing AMA-MSS policy, or raise awareness of a specific issue and stimulate conversations. The majority of respondents had heard about the varying advocacy channels (GC action item, reaching out to the BoT MSS member, working with MSS standing committees, working with state and county medical societies); however, many MSS members opted for the resolution-writing route. Respondents cited a few different etiologies for doing so: a desire to integrate novel ideas into the policy digest, updating the AMA’s stance on time-sensitive issues, desiring action for lobbying or health policy, increasing their involvement in the AMA-MSS and engaging in healthcare policy, and ensuring their passion had concrete, actionable aims via policy implementation. Lowest ranking reasons included resolution topics related to authors’ research, receiving funding for a national meeting, and the desire to participate in an activity with peers. This is loosely correlated with the fact that students do not often reach out to other students to recruit authors or reach out to state or specialty societies.

Funding:
85.36% of respondents have received funding to attend national AMA-MSS meetings. While this was a “select all that applies” question, the most respondents (26/145; 17.93%) stated they served as an MSS Chapter Delegate or Alternate Delegate to receive funding. Other popular means of obtaining funding included being an author on an MSS resolution (15/145), presenting a research poster (18/145), or participation in the AMA HOD (16/145).

Respondents also noted a strong desire for a mentorship during the resolution process. Multiple respondents indicated that mentorship would be an efficacious way to ensure high-quality, non-repetitive resolutions while teaching the younger MSS members how to develop their resolution writing abilities. Many respondents felt the turnaround time between resolution deadlines was quite abbreviated, which potentially impacts the quality of the resolution being submitted.
CONCLUSIONS AND RECOMMENDATIONS

This report demonstrates that the resolution process is highly valued among medical student members, and the desire to be involved is rooted in health advocacy. Students are consistently writing resolutions and attending meetings to engage in the discussion of important topics with students from across the nation. Thus, it is highly imperative that the resolution process continue to evolve to reflect the needs of the MSS Assembly.

Your COLRP recommends the following actions be taken:

- Raise awareness of the alternative options for advocacy and how these routes align with the MSS’s and AMA’s strategic initiatives; specifically how the AMA can take action on a topic without the prerequisite of introducing a resolution to the House of Delegates.

- Raise awareness of the availability of resources in writing resolutions especially with State Societies, Specialty Societies, and Region-specific materials.

- Promote mentorship of younger members and new authors to improve resolution quality and to teach inexperienced authors how to navigate the nuances of the resolution process.

- Review and possible reformatting of the resolution process deadlines to better accommodate the large variability of student schedules, which may include earlier release of deadlines, granting more time between deadlines, and also better aligning Region-specific deadlines with the overall process deadlines.

ACKNOWLEDGEMENTS:

This report was assembled by members of the 2017-2018 AMA-MSS Committee on Long Range Planning (Lauren Engel, Pranja Gupta, Rebecca Haines, Maren Loe, Aleesha Shaik, Morgan Stalder, Aaron Wolbrueck).
REPORT OF THE MSS RESOLUTION PROCESS TASK FORCE

MSS RTF Report 1-A-18

Subject: Reforms to the Resolution Process: Recommendations from the MSS Resolution Task Force

Presented by: MSS Resolution Process Task Force
Helene Nepomuceno, Co-Chair and Karthik V. Sarma, Co-Chair

Referred to: MSS Governing Council
(Helene Nepomuceno, Chair; Karen Dionesotes, Vice-Chair and Chair-Elect)

INTRODUCTION

At the 2017 Interim Meeting of the AMA Medical Student Section (MSS), the Assembly received an unprecedented number of resolutions for discussion and evaluation. This volume of business raised concerns about the functionality and capacity of the current resolution process, prompting the MSS Governing Council (GC) to convene a MSS Resolution Process Task Force (RTF) to make recommendations on improvements to strengthen the current resolution process. In particular, the GC asked for recommendations that would address concerns about:

a. Insufficient time for adequate discussion of resolutions in the Assembly
b. Impact on student leadership (incl. sectional and regional delegates as well as the House Coordinating Committee)
c. Impact on AMA staff (incl. MSS staff and non-MSS experts)
d. Number of external resolutions forwarded to House of Delegates

This report presents recommendations for resolution process reforms that the RTF believes will encourage mentorship within the MSS, protect the democratic opportunity to be heard, foster high-quality discussion in the MSS Assembly, and preserve resources for the advocacy of MSS-originated resolutions in the AMA House of Delegates (HOD). This report also presents the results of an investigation of the current resolution process and its origins through interviews with various stakeholders.

RESOLUTION TASK FORCE PROCEDURE

After approving the charter convening the RTF, the MSS GC reached out to Region Governing Council Chairs and Vice Chairs to request nominations for two representatives to represent each Region. Previous efforts to reform the resolution process have met with limited success due to a lack of adequate engagement across the full MSS, and thus the GC prioritized equal representation from all regions on the RTF.

In addition to two representatives from each Region, the RTF membership also included the MSS Section Delegates to provide input based on their expertise in the resolution process and as GC representatives. The MSS Councilor on Constitution and Bylaws was included to ensure that any discussed recommendations were not in conflict with the AMA Bylaws and to advise on which recommendations may require changes to the MSS Internal Operating Procedures. The region representatives, MSS Section Delegates, and the MSS Councilor on Constitution and

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1 The full charter convening the RTF can be viewed in Appendix A.
Bylaws comprised the voting members of the RTF. The MSS Speakers were included as permanent, non-voting guests, and various other student leaders and AMA staff were invited as guests when pertinent. The RTF was led by the MSS Chair and the Student Member of the AMA Board of Trustees.

The final membership for the RTF appears below:

<table>
<thead>
<tr>
<th>Role</th>
<th>Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task Force Co-Chairs</td>
<td>MSS Chair: Helene Nepomuceno</td>
</tr>
<tr>
<td></td>
<td>MSS Trustee: Karthik V. Sarma</td>
</tr>
<tr>
<td>Task Force Members</td>
<td>MSS Councilor on Constitution and Bylaws: Joy Lee</td>
</tr>
<tr>
<td></td>
<td>MSS Delegate: Jerome Jeevarajan</td>
</tr>
<tr>
<td></td>
<td>MSS Alternate Delegate: Kieran McAvoy</td>
</tr>
<tr>
<td></td>
<td>Region 1 Representative: Adam Roussas</td>
</tr>
<tr>
<td></td>
<td>Region 1 Alternate: Danny Hintze</td>
</tr>
<tr>
<td></td>
<td>Region 2 Representative: Lauren Engel</td>
</tr>
<tr>
<td></td>
<td>Region 2 Alternate: Blake Murphy</td>
</tr>
<tr>
<td></td>
<td>Region 3 Representative: Luis Seija</td>
</tr>
<tr>
<td></td>
<td>Region 3 Alternate: William Ross</td>
</tr>
<tr>
<td></td>
<td>Region 4 Representative: Taylor Lucas</td>
</tr>
<tr>
<td></td>
<td>Region 4 Alternate: Jessica Walsh O'Sullivan</td>
</tr>
<tr>
<td></td>
<td>Region 5 Representative: Joshua Donkin</td>
</tr>
<tr>
<td></td>
<td>Region 5 Alternate: Michelle Knopp</td>
</tr>
<tr>
<td></td>
<td>Region 6 Representative: James Ting</td>
</tr>
<tr>
<td></td>
<td>Region 6 Alternate: Pauline Huynh</td>
</tr>
<tr>
<td></td>
<td>Region 7 Representative: Kate Topalis</td>
</tr>
<tr>
<td></td>
<td>Region 7 Alternate: Breyen Coffin</td>
</tr>
<tr>
<td>Task Force Guests</td>
<td>MSS Speaker: Anna Yap</td>
</tr>
<tr>
<td></td>
<td>MSS Vice Speaker: Jay Llaniguez</td>
</tr>
<tr>
<td></td>
<td>MSS Director: Haley Guion, JD</td>
</tr>
<tr>
<td></td>
<td>MSS Policy Analyst: Hannah Handal</td>
</tr>
<tr>
<td></td>
<td>George E Cox III, JD, Director, Division of Legislative Counsel</td>
</tr>
<tr>
<td></td>
<td>William Estes, Government Relations Advocacy Fellow</td>
</tr>
<tr>
<td></td>
<td>Christopher Clifford, Council on Legislation</td>
</tr>
<tr>
<td></td>
<td>Ryan Ribeira, MD, MPH, MSS Delegate 2011-2012</td>
</tr>
<tr>
<td></td>
<td>Cameron Paterson, MD, MSS Delegate 2015-2016</td>
</tr>
<tr>
<td></td>
<td>Sarah Mae Smith, MSS Delegate 2016-2017</td>
</tr>
</tbody>
</table>

The RTF held four conference calls over a two-month period. The first and second calls were information-gathering meetings on the current and past resolution process. RTF members and other stakeholders submitted proposals to reform the resolution process between the second and third conference calls. On the third call, the RTF first established criteria they believed were reflective of a resolution process worth striving toward. The criteria below were established by a two-thirds majority vote of the RTF:

- Improves the quality of resolutions
- Establishes clear standards
- Minimizes reviewer bias
- Fosters mentorship
- Creates or furthers opportunities for discussion during the Assembly
- Ensures democratic opportunity
- Improves efficient resource utilization
- Feasible effort necessary for implementation

The RTF went on to discuss how the submitted proposals addressed each of these criteria, with the understanding that no proposal would fulfill all the criteria and that a set of proposals would have to be recommended to fulfill all the criteria. This discussion continued through the fourth conference call, and the RTF voted on which proposals should be recommended as resolution process reforms. Recommendations were established by a two-third majority vote of the RTF.

RESOLUTION PROCESS BACKGROUND

The first purpose of the AMA MSS is to provide “meaningful input into the decision and policy-making process of the AMA.” The MSS achieves this purpose in part by participating in the AMA HOD through the submission of MSS-authored resolutions. To be considered by the HOD, MSS-authored resolutions must first be submitted to the MSS Assembly by MSS member(s).

The purpose of the MSS Assembly is “to adopt resolutions for MSS Policy and for submission to the House of Delegates of the AMA.” The MSS Internal Operating Procedures guarantee that any MSS member may submit resolutions for consideration. If the resolution secures a simple majority vote for adoption by the Assembly, it can be incorporated into the MSS Digest of Policy Actions or forwarded for consideration by the AMA HOD as an MSS-authored resolution.

Resolution Process

This report defines the “resolution process” as the stepwise process that begins with idea submission to the MSS Open Forum and ends with advocacy for the resolution by the MSS Caucus at the HOD. The resolution process encompasses the several months of preparation leading up to the MSS Assembly, duration of the Assembly, and several months of preparation leading up to the following HOD. Figure 1 provides a visual breakdown of the steps in the resolution process and responsibilities of each party involved. Each step is driven by a submission by the resolution author, which triggers multiple levels of feedback – and in later steps, assessment – from other medical students and AMA staff.

Step 1: Open Forum
The purpose of the MSS Open Forum is to provide a venue for potential resolution authors to share their ideas, receive early feedback, and connect with interested students and potential co-authors. Various levels of MSS leadership provide feedback at this step, notably the Section Delegates and the House Coordinating Committee. The author is responsible for incorporating feedback from the Open Forum as they draft their resolution.

Step 2: Draft Submission
Approximately 10 weeks prior to the MSS Assembly, the author submits a draft resolution, which spurs another round of feedback from various levels of MSS leadership. This round of feedback is organized by the Section Delegates so that each resolution receives adequate attention. The purpose of this feedback is to tailor high-quality final resolutions for consideration by the MSS Assembly.

Step 3: Final Submission
After incorporating feedback from their draft resolutions, authors submit a final resolution which

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2 AMA MSS Internal Operating Procedures II.A.
3 AMA MSS Internal Operating Procedures X.D.5.
4 AMA MSS Internal Operating Procedures X.H.1.
5 AMA MSS Internal Operating Procedures X.H.8.
prompts a round of scoring and internal staff feedback. The Section Delegates assign the resolutions so that each resolution is scored against the resolution scoring rubric by six Regional Delegates and one House Coordinating Committee (HCC) member. The scores are averaged and used to create an order of consideration that will be used during the Assembly. Concurrently, MSS staff refers almost all resolutions for relevant expert input by other staff within the AMA, including federal and state advocacy staff and legal review. MSS staff notes that it takes fewer resources to review internal resolutions than external resolutions. The resulting staff input is compiled into the Reference Committee background book, and also informs the calculation of the fiscal note (the estimated cost of implementing the Resolved clauses of the resolution).

Step 4: Virtual Reference Committee
The MSS is the only section within the AMA that uses a fully virtual Reference Committee (VRC). The role of the Reference Committee is to recommend an action on each resolution that will be placed before the Assembly, drawing on member testimony, staff background, and committee member expertise and research. Through the VRC process, all testimony that would have been provided before an in-person Reference Committee is instead provided through MSS online forums. After the VRC closes, the Reference Committee meets via conference call to deliberate and render its recommendation for each resolution. These recommendations are compiled into the Reference Committee Report.

Step 5: Assembly
The Reference Committee Report comprises the main motions that establish the business of the MSS Assembly. The Assembly is presided over by the MSS Speaker and Vice Speaker and guided by parliamentary procedure. During the Assembly, MSS members have an opportunity to debate each resolution. There are also multiple opportunities throughout the meeting for authors to engage with other students and build support for their resolutions, such as during Region Policy Meetings. If the Assembly votes to adopt a resolution, the Resolved clauses are either incorporated into the MSS Digest of Policy Actions ("internal resolutions") or forwarded to the HOD as an MSS-authored resolution ("external resolutions").

Step 6: HOD
External resolutions that have been adopted by the MSS Assembly are generally sent to the HOD at the subsequent AMA meeting – for example, external resolutions adopted at Annual will be business of the HOD at Interim. Prior to and throughout the HOD meeting, the Section Delegates, Regional Delegates, student members of State Delegations, and HCC strategize on how to best support MSS-authored resolutions to improve their chances of adoption by the HOD. The author is encouraged to remain involved with their resolution throughout this time and may have an opportunity to provide in-person testimony before a HOD Reference Committee or the HOD.

6 The Annual 2018 Resolution Scoring Rubric can be viewed in Appendix B.
<table>
<thead>
<tr>
<th><strong>Figure 1. Overview of the Resolution Process</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Open Forum</strong> (12 weeks prior to Assembly)</td>
</tr>
<tr>
<td><strong>Author</strong></td>
</tr>
<tr>
<td><strong>Section Delegates</strong></td>
</tr>
<tr>
<td><strong>Region Delegation Chair (RDC)</strong></td>
</tr>
<tr>
<td><strong>Regional Delegates</strong></td>
</tr>
<tr>
<td><strong>House Coordinating Committee (HCC)</strong></td>
</tr>
<tr>
<td><strong>MSS Committees</strong></td>
</tr>
<tr>
<td><strong>MSS Councilors</strong></td>
</tr>
<tr>
<td>Role</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>MSS Staff</td>
</tr>
<tr>
<td>Advocacy Staff (DC)</td>
</tr>
<tr>
<td>Office of the General Counsel</td>
</tr>
<tr>
<td>Reference Committee</td>
</tr>
<tr>
<td>MSS Assembly</td>
</tr>
</tbody>
</table>

- Feedback
- Create order of consideration based on resolution scores
- Collect background materials from authors
- Refer resolutions for expert staff input and production of fiscal notes
- Collect all materials into background book for Reference Committee
- Organize logistics of the VRC
- Continue collecting materials from authors and staff
- Pass along relevant information to Section Delegates
- Support Reference Committee
- Organize logistics of MSS Assembly
- Testify on Reference Committee recommendations when appropriate
- Provide guidance where relevant
- Vote on resolution adoption
### Challenges in the Current Resolution Process

The RTF conducted interviews with MSS staff, advocacy staff, and current and past Section Delegates. From these conversations, the following challenges were continually cited in the resolution process.

<table>
<thead>
<tr>
<th>Step</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Forum</td>
<td>- Large volume of ideas on the Open Forum makes providing timely feedback on all ideas challenging.</td>
</tr>
<tr>
<td>Draft Submission</td>
<td>- Not all Regional Delegates provide timely feedback.</td>
</tr>
<tr>
<td></td>
<td>- Secondary reviews are sometimes inadequate.</td>
</tr>
<tr>
<td></td>
<td>- Due to rules about Regional Delegate review, differences in the number of resolutions submitted by each Region results in inequality in the number of resolutions each Regional Delegate is required to review.</td>
</tr>
<tr>
<td>Final Submission</td>
<td>- Not all Regional Delegates score resolutions on time.</td>
</tr>
<tr>
<td></td>
<td>- Difficult to get staff-generated comments to authors in a timely manner.</td>
</tr>
<tr>
<td></td>
<td>- Higher volumes limit the quality of staff review that can be conducted on each resolution.</td>
</tr>
<tr>
<td></td>
<td>- Staff review occurs concurrently with other staff responsibilities, such as preparing for HOD and federal advocacy responsibilities.</td>
</tr>
<tr>
<td></td>
<td>- Turnaround on review – student and staff – is short, usually around one week.</td>
</tr>
<tr>
<td></td>
<td>- Due to rules about Regional Delegate review, differences in the number of resolutions submitted by each Region results in inequality in the number of resolutions each Regional Delegate is required to review.</td>
</tr>
<tr>
<td>VRC</td>
<td>- Posting testimony occurs right before VRC closes, diminishing the quality of debate that can be conducted.</td>
</tr>
<tr>
<td>Assembly</td>
<td>- Higher volumes limit the amount of time that can be spent debating each resolution, constraining discussion and lowering the quality of debate.</td>
</tr>
<tr>
<td>HOD</td>
<td>- Increased volume makes allocation of MSS representatives and MSS political capital difficult.</td>
</tr>
<tr>
<td></td>
<td>- Difficult to contact all relevant sections and specialty societies to ensure support for each external resolution.</td>
</tr>
<tr>
<td></td>
<td>- Not all Regional Delegates provide timely review on resolutions.</td>
</tr>
</tbody>
</table>

### Non-Resolution Avenues for Advocacy

While authoring resolutions is an important avenue through which the MSS fulfills its purpose to impact AMA policy, there is a number of other avenues that will achieve the same purpose and are in some cases more appropriate courses of action for certain issues. The GC has been actively promoting awareness of these avenues. A sample of alternative avenues is listed below.

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7 For example, alternative avenues are listed in the Resolution Guide, which is displayed in Appendix C.
• GC Action Item Request: Students can submit a request for issues that can be resolved by action on the part of the GC.
• Action through state and county medical societies: Students can work through local organized medicine bodies for issues that are specific to one setting.
• Action through specialty medical societies: Students can work through specialty medical societies for issues that are specific to one specialty.
• Action through MSS Standing Committees: Students can collaborate with MSS Standing Committees to produce materials, programming, and other deliverables on issues already addressed within AMA and/or MSS policy.

PROPOSALS CONSIDERED BY THE RESOLUTION PROCESS TASK FORCE

The proposals considered by the RTF were divided into six stages corresponding to the steps of the resolution process or time between steps in the resolution process:

1. Education and Infrastructure: This stage occurs prior to the resolution process, and involves providing educational resources and initiatives to prepare MSS members to go through the resolution process.
2. Brainstorming Stage: This stage overlaps with the Open Forum up through draft resolution submission. Proposals in this stage focus on getting earlier feedback to students.
3. Revision Stage: This stage covers the time after draft resolution submission and before final resolution submission. Proposals in this stage consider ways to make resolution feedback more accessible to authors and other MSS leadership and ways to increase cross-regional collaboration.
4. Scoring Stage: This stage assesses the scoring rubric used by Regional Delegates and HCC during the resolution scoring step.
5. VRC/Reference Committee Stage: This stage overlaps with the opening of the VRC and the creation of the Reference Committee report. Proposals in this stage focus on making information more accessible to the Reference Committee and MSS members and increasing engagement in the VRC.
6. Assembly Stage: This stage overlaps with the duration of the MSS Assembly. Proposals in this stage aim to protect the ability of the Assembly to have high-quality debate.

A total of 49 proposals were considered. As described in the RTF Procedure, each proposal was discussed twice by the RTF before recommendation for resolution process reform was determined by a two-thirds majority vote. The following is a summary of the RTF discussion on each proposal.

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8 A listing of all proposals divided by stage can be viewed in Appendix D.
A. Education and Infrastructure

1. Train RD/ADs to provide better guidance on the various mechanisms available for advocacy through the AMA and MSS.
2. Create a formal document and/or talking points to provide to members as proof of significant, non-resolution related work (i.e. serving as a Delegate, in leadership, on a committee, etc.) which they can provide as support for conference funding and time-off requests.
3. Make a video explaining the basics of Parliamentary Procedure and the most common mistakes people make.
4. Create a PolicyFinder for AMA-MSS policy to replace the current PDF.
5. Publicize GC Action Item Requests widely and increase the prestige of these proposals. For example, requesters can present GC Action Item Requests during a programming session.
6. Define an individual on each Region GC whose can be contacted by other Regions to collaborate during the resolution process.

<table>
<thead>
<tr>
<th>Proposal</th>
<th>Criteria Fulfilled</th>
<th>Recommendation</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>Improves the quality of resolutions; Fosters mentorship; Improves efficient resource utilization</td>
<td>Recommend</td>
<td>The other mechanisms available for advocacy include the alternative avenues addressed previously (e.g. GC action item request) and are also covered in the Resolution Alternatives published on the AMA website.9</td>
</tr>
<tr>
<td>A2</td>
<td>Fosters mentorship; Improves efficient resource utilization</td>
<td>Recommend</td>
<td>This proposal is for a general document that would be similar to the form letter the RFS provides to its members. The document would describe the purpose of the meeting and justify why students should be able to attend and receive funding. The GC began providing template letters for people who are serving in leadership roles to validate their importance to the Assembly. There may be value in a further individualized document.</td>
</tr>
<tr>
<td>A3</td>
<td>Creates or furthers opportunities for discussion during the Assembly; Ensures democratic opportunity</td>
<td>Recommend</td>
<td>The RTF acknowledged the potential implementation burden for staff associated with creating a video; however, RTF members noted that there are students with the requisite skills who would be willing to contribute. Explanatory videos for topics aside from parliamentary procedure may also be useful.</td>
</tr>
<tr>
<td>A4</td>
<td>Improves the quality of resolutions; Improves efficient resource utilization</td>
<td>Do not recommend</td>
<td>There was debate in the RTF on whether a PolicyFinder would be more or less accessible than the current PDF Digest of Policy Actions. It was suggested that both remain available if this proposal was recommended. There were also concerns that a PolicyFinder would create confusion as to what is MSS policy and what is AMA policy. The creation of a MSS PolicyFinder might also lead to other sections with internal policy (the RFS and YPS) asking for a similar tool. The amount of implementation effort required for this proposal was uncertain.</td>
</tr>
<tr>
<td>A5</td>
<td>Improves the quality of resolutions; Improves efficient resource utilization</td>
<td>Recommend</td>
<td>The RTF generally supported this proposal. There were some concerns about whether this proposal would create a large volume of GC Action Items.</td>
</tr>
<tr>
<td>A6</td>
<td>Improves the quality of resolutions;</td>
<td>Do not recommend</td>
<td>This proposal arose from difficulties in finding the correct person to coordinate cross-regional efforts. However, several region representatives noted that regions have</td>
</tr>
</tbody>
</table>

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9 The Resolution Alternatives can be viewed in Appendix E.
B. Brainstorming Stage (Pre-Draft Submission)

1. Have a MSS leader analyze the Open Forum for resolutions that the AMA Federal Advocacy Office would be interested in reviewing. The MSS leader will give a preliminary ranking and recommendation to each idea (similar to HCC). They will then forward the list and assessments on to the GRAF, who will determine which ones elevate to the level of staff input.
   a. MSS leader could be the student COL member or the Section Delegates and Region Delegation Chairs.
2. Have the GRAF monitor the Legislation and Advocacy subfolder on the Open Forum.
3. Have students submit resolution ideas to Regional leadership (e.g. the policy chair), who will then post the idea to the proper Open Forum category.
4. Have an indicator on the Open Forum that shows if the originator is a first-time author. This visibility would allow more experienced writers to help the new authors and mentor them through the process.

<table>
<thead>
<tr>
<th>Proposal</th>
<th>Criteria Fulfilled</th>
<th>Recommendation</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1</td>
<td>Improves the quality of resolutions; Improves efficient resource utilization; Feasible effort necessary for implementation</td>
<td>Recommend</td>
<td>The RTF appreciated that this proposal provided earlier feedback to potential authors of advocacy resolutions while streamlining the process of advocacy staff review. Since there are many entries in the Open Forum, the RTF agreed that multiple student leaders should split the responsibility, and specifically named the GRAF, MSS Councilor on Legislation, Section Delegates, and Region Delegation Chairs.</td>
</tr>
<tr>
<td>B2</td>
<td></td>
<td>Do not recommend</td>
<td>This proposal was combined with B1 above.</td>
</tr>
<tr>
<td>B3</td>
<td></td>
<td>Do not recommend</td>
<td>The RTF felt that allowing potential authors to categorize their own submissions to the Open Forum provided information on how potential authors saw their own ideas and served as a valuable learning experience.</td>
</tr>
<tr>
<td>B4</td>
<td>Improves the quality of resolutions; Fosters mentorship; Improves efficient resource utilization</td>
<td>Recommend</td>
<td>The RTF supported this proposal and likened it to the first-time attendee stickers that are used at meetings. However, the RTF had questions about how this proposal would be implemented and wondered if staff could set up a visible indicator could be set up on the Open Forum.</td>
</tr>
</tbody>
</table>
C. Revision Stage (Post-Draft Submission, Pre-Final Submission)

1. Emphasize feedback on resolutions that do not receive State or Regional support, e.g. ask Regions to submit formal reasoning behind why they chose NOT to support a policy, or having additional reviewers on single-author resolutions.
2. Broaden the functional scope of the HCC so HCC members can contact Region leaders to improve resolutions that would otherwise likely be reaffirmed.
3. Make HCC review summaries easily available in a compiled report.
4. Primary reviewers must send feedback summary emails to the primary author’s Region Chair and Region Delegation Chair in order to allow Regions to incorporate draft feedback into their Region authorship voting if they choose to.
5. All external resolutions are required to have Region authorship.
   a. Addendum: Regions are capped at supporting 5 external resolutions written primarily by their own members.
6. All external resolutions must have cross-regional authorship.
7. All external resolution authors must contact the relevant specialty society prior to submission.
8. All resolutions must have cross-regional authorship.
9. Coordinate Region resolution authorship/support through a central AMA email process so more medical school sections can be reached.
10. All members of the MSS Caucus (RDs/ADs + state ADs) vote on whether they believe the resolution should be considered at the Assembly, and only resolutions above some threshold are allowed to advance to the final resolution phase.
11. Upon submission of a final draft, having authors of external resolutions virtually sign an acknowledgement saying that they understand that, if passed, that their resolution will be forwarded to the AMA HOD at the subsequent meeting and that they will help the Section Delegates and MSS RD/ADs in bringing their resolution to the AMA HOD. This would include but not be limited to updating whereas clauses for the next meeting with the most up to date literature, crafting testimony for the VRC and live Reference Committee hearings, and reaching out to specialty societies.

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<tr>
<th>Proposal</th>
<th>Criteria Fulfilled</th>
<th>Recommendation</th>
<th>Discussion</th>
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<tbody>
<tr>
<td>C1</td>
<td>Improves the quality of resolutions</td>
<td>Do not recommend</td>
<td>The RTF noted that each Region uses different standards to determine whether to provide support for resolutions, thus passing this proposal may not be equitable across Regions. In addition, the proposal was deemed to be unduly harsh for newer resolution authors.</td>
</tr>
<tr>
<td>C2</td>
<td>Improves the quality of resolutions; Fosters mentorship; Improves efficient resource utilization</td>
<td>Recommend</td>
<td>This proposal intends to provide HCC with the additional ability to email Region leadership, adding on to the existing process where they leave feedback on the draft resolutions directly. It should be noted that “improvement” includes encouraging mergers between similar resolutions and the elimination of resolution topics that duplicate existing policy. Giving HCC the ability to contact Region leadership about resolutions that may be recommended against adoption was discussed, but rejected as outside the purview of HCC. Several members of the RTF also noted that it would be helpful for Region members to know who the HCC members were in each Region, in order to facilitate two-way communication.</td>
</tr>
<tr>
<td>C3</td>
<td>Improves the quality of resolutions</td>
<td>Do not recommend</td>
<td>This proposal arose from a desire to make HCC feedback more readily available to all members. However, the RTF was unable to come to consensus on which stage the HCC feedback should be collated at, and what additional value it would provide since HCC posts its feedback on the VRC and therefore HCC feedback is already incorporated in the Reference Committee Report when relevant.</td>
</tr>
<tr>
<td>C4</td>
<td>Improves the quality of</td>
<td>Recommend</td>
<td>This proposal arose from the desire to provide Region leadership with more</td>
</tr>
<tr>
<td>Proposal</td>
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<tr>
<td>resolutions; Fosters mentorship; Improves efficient resource utilization</td>
<td>information when they are determining which resolutions to provide Region authorship to. The process for determining Region authorship varies between Regions, so the Region Chair and Region Delegation Chair should forward the primary reviewer feedback to the appropriate body.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C5</td>
<td>Do not recommend</td>
<td>This proposal was dismissed as another form of a cap on the number of resolutions. It was also noted that the difference in Region authorship determination between Regions could set the bar higher in some Regions than others, potentially stifling good work.</td>
<td></td>
</tr>
<tr>
<td>C6</td>
<td>Do not recommend</td>
<td>The proposal received the same criticisms as C5, with the additional comment that it is more restrictive on new potential authors.</td>
<td></td>
</tr>
<tr>
<td>C7</td>
<td>Recommend</td>
<td>This proposal codifies an existing process.</td>
<td></td>
</tr>
<tr>
<td>C8</td>
<td>Do not recommend</td>
<td>This proposal received the same criticisms as C5 and C6.</td>
<td></td>
</tr>
<tr>
<td>C9</td>
<td>Recommend</td>
<td>While the RTF supported this proposal, there was discussion on how it would be implemented without invading member privacy. The new Region newsletter initiative was cited. The RTF notes that GC would have to give more thought to the feasible implementation of this proposal.</td>
<td></td>
</tr>
<tr>
<td>C10</td>
<td>Do not recommend</td>
<td>The RTF commented that this proposal might introduce more bias into the resolution process, and rejected it for that reason.</td>
<td></td>
</tr>
<tr>
<td>C11</td>
<td>Recommend</td>
<td>The RTF noted that this proposal is a formalization of existing practice. They agreed that the document should be clear that once an external resolution has become business of the HOD, the MSS Caucus takes ownership and has the final authority to direct what strategy and action should be taken on the resolution.</td>
<td></td>
</tr>
</tbody>
</table>
D. Scoring Stage

1. Resolutions should be scored based on authorship (section, state, region).
2. Resolutions should be scored based on clarity.
3. Resolutions should be scored based on research quality.
4. Resolutions should be scored based on scope.
5. Resolutions should be scored based on feasibility.
6. Resolutions should be scored based on novelty.
7. Resolutions should be scored based on how well they address AMA Strategic Focus Areas.
8. Resolutions should be scored based on how well they address MSS Policy Objectives.
   a. The Section Delegates should be responsible for conducting an annual survey which sets the MSS Policy Objectives for the given year.
   b. A resolution’s score of how well it addresses MSS Policy Objectives should make up a larger proportion of the overall score (currently 10%).
9. Resolutions should be scored based on whether they responded to feedback.
10. Resolutions should be scored on a quantitative scale.
11. Resolutions should be scored with consideration of their fiscal note.

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<tbody>
<tr>
<td>D1</td>
<td>Improves the quality of resolutions; Establishes clear standards; Fosters mentorship</td>
<td>Recommend</td>
<td>There was discussion about whether inter-region variance in determining Regional authorship makes this a less reliable metric, but in general the RTF agreed that it makes sense to give weight to the resolutions that are important to a larger proportion of the electorate. The process of gaining local or regional authorship is also a good learning experience for building coalitions at HOD.</td>
</tr>
<tr>
<td>D2</td>
<td>Improves the quality of resolutions; Establishes clear standards</td>
<td>Recommend</td>
<td>The RTF discussed whether clarity should have been ensured earlier in the feedback process, but agreed that this metric constituted an important final filter as well as a useful indicator when the resolution rubric is used to provide a draft score to the authors.</td>
</tr>
<tr>
<td>D3</td>
<td>Improves the quality of resolutions; Establishes clear standards; Creates or furthers opportunities for discussion during the Assembly</td>
<td>Recommend</td>
<td>There was limited discussion on whether the weight of this metric was too high.</td>
</tr>
<tr>
<td>D4</td>
<td>Improves the quality of resolutions; Establishes clear standards</td>
<td>Recommend</td>
<td>Some members of the RTF noted that “scope” is a very subjective metric. However, the RTF still found this metric useful.</td>
</tr>
<tr>
<td>D5</td>
<td>Improves the quality of resolutions; Establishes clear standards; Creates or furthers opportunities for discussion during the Assembly</td>
<td>Recommend</td>
<td>The RTF believes that scope and feasibility are two separate categories and should be listed as such on the resolution rubric. Feasibility includes the fiscal note to some extent.</td>
</tr>
<tr>
<td>Proposal</td>
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<tr>
<td>D6</td>
<td>Improves the quality of resolutions</td>
<td>Recommend</td>
<td>The RTF noted that this was one of the most useful criteria.</td>
</tr>
<tr>
<td>D7</td>
<td></td>
<td>Do not recommend</td>
<td>The RTF does not believe that a resolution has to correspond with the AMA Strategic Focus Areas to qualify as a high-quality resolution, and would recommend its removal from the resolution rubric. Awareness of the AMA Strategic Focus Areas can be incorporated in the educational process for resolution writing.</td>
</tr>
<tr>
<td>D8</td>
<td></td>
<td>Recommend</td>
<td>The RTF made the differentiation between alignment with the AMA Strategic Focus Areas and the MSS Policy Objectives as follows: since the MSS is an independent section within the AMA, the MSS Policy Objectives allow the MSS to set a unified policy direction that it can affect within the broader AMA compendium. Narrower policy objectives that are nimble enough to change on an annual basis can help the MSS present a coherent, united, and continuous advocacy effort in the HOD. The RTF discussed the significant implementation effort associated with part (a) of this proposal (conducting an annual survey), and noted that an in-person survey would be more effective. The RTF rejected part (b) of this proposal, opting not to recommend an increase to the proportion of the overall score.</td>
</tr>
<tr>
<td>D9</td>
<td>Improves the quality of resolutions; Establishes clear standards</td>
<td>Recommend</td>
<td>The RTF noted that “responded to feedback” should be interpreted as “thoughtful response”.</td>
</tr>
<tr>
<td>D10</td>
<td></td>
<td>Recommend</td>
<td>The RTF was not fully comfortable with a quantitative scale, but given the fact that it is only used to order resolutions for consideration, they could not determine a better metric.</td>
</tr>
<tr>
<td>D11</td>
<td>Improves the quality of resolutions; Establishes clear standards; Minimizes reviewer bias</td>
<td>Do not recommend</td>
<td>The RTF did not find a significant association between the quality of a resolution and its fiscal note. They noted that it may be more necessary to discuss items with high fiscal notes earlier in the Assembly, which would not happen if resolutions were penalized for a high fiscal note.</td>
</tr>
</tbody>
</table>
E. VRC/Reference Committee Stage

1. Create a new Reference Committee recommendation category named “recommend for GC action item.”
2. Adjust resolution deadlines to allow more time for review between the final submission and VRC.
3. Release the list of final resolutions prior to VRC opening so that regions and states will have more time to organize their resolution review processes.
4. Have HCC post a summary of their comments from the draft review process to the VRC.
5. After final resolutions are submitted, the HOD Coordination Committee (HCC) will review all submissions and place items on a Reaffirmation Consent Calendar based on simple majority voting within the Committee. The selected items will not receive detailed staff review except analysis from Legal Counsel. The selected items will be displayed on the Virtual Reference Committee as “Reaffirmation Consent Calendar” separate from the Resolutions folder and Reports folder. The Reaffirmation Consent Calendar will be open for comments on the VRC but will not be business of the MSS Assembly unless extracted during the MSS Assembly Opening Session.
6. Have RD/ADs provide meaningful testimony on the VRC for resolutions they reviewed, especially in cases where important recommendations were not considered.
7. Conduct debate on lower scoring resolutions in a live forum where people can vote ahead of the Assembly. The vote can eliminate resolutions before the Assembly.

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<tbody>
<tr>
<td>E1</td>
<td>Fosters mentorship; Ensures democratic opportunity; Improves efficient resource utilization</td>
<td>Recommend</td>
<td>This proposal arose from a desire to enable the Reference Committee to recommend further action on a resolution that duplicates existing policy but calls for further action. The RTF supported the idea but noted there would have to be clarifications in the parliamentary procedure implementation. The hope is that implementing this proposal lessens the number of extractions from the reaffirmation calendar and consequent wordsmithing on the floor.</td>
</tr>
<tr>
<td>E2</td>
<td>Improves the quality of resolutions; Fosters mentorship</td>
<td>Recommend</td>
<td>This proposal is aimed at giving all members, but especially those who need to provide testimony, more time to review final resolutions.</td>
</tr>
<tr>
<td>E3</td>
<td>Improves the quality of resolutions</td>
<td>Do not recommend</td>
<td>This proposal had a similar aim to E2, but discussion of its implementation revealed that there is no way to publicly release the list of final resolutions earlier due to time needed for staff review. Therefore the RTF did not recommend this.</td>
</tr>
<tr>
<td>E4</td>
<td>Fosters mentorship</td>
<td>Recommend</td>
<td>It was noted that this proposal should not apply if authors replied to HCC draft feedback.</td>
</tr>
<tr>
<td>E5</td>
<td>Improves the quality of resolutions; Creates or furthers opportunities for discussion during the Assembly</td>
<td>Recommend</td>
<td>This proposal brings MSS procedure in line with HOD procedure, and lessens the volume of staff review needed. There was concern that this proposal may violate democratic opportunity, which would have to be rectified by running a transparent and educated process. The RTF also noted that a corresponding process for reaffirmation calendar extraction and subsequent Reference Committee review would have to be drawn up. The RTF suggested amending this proposal to also allow HCC to make recommendations for the new “recommend for GC Action Item” category, and to include medical student section delegates to help alleviate the burden of giving HCC multiple new roles.</td>
</tr>
<tr>
<td>E6</td>
<td>Improves the quality of</td>
<td>Recommend</td>
<td>The RTF noted that posting on the VRC is up to the discretion of the individual</td>
</tr>
<tr>
<td>Proposal</td>
<td>Criteria Fulfilled</td>
<td>Recommendation</td>
<td>Discussion</td>
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</tr>
<tr>
<td>E7</td>
<td>resolutions;</td>
<td>Do not</td>
<td>The RTF felt that this proposal decreased democratic opportunity too greatly.</td>
</tr>
<tr>
<td></td>
<td>Fosters mentorship; Creates or furthers opportunities for discussion during the Assembly</td>
<td>recommend</td>
<td>Regional Delegate and this proposal should not apply if the authors adequately addressed draft feedback.</td>
</tr>
</tbody>
</table>
### F. Assembly Stage

1. Create the Assembly’s Order of Business according to resolution scores.
2. Cap the number of resolutions for discussion at the Assembly.
3. Cap the number of resolution that can be forwarded to the HOD from each Assembly.
4. Designate specific microphones as PRO, CON, and repeat speaker microphones.
5. Provide a report after each Assembly meeting on the impact of the resolutions passed.
6. Establish a threshold vote required to extract a resolution.
7. Place a time limit on discussion for each resolution or on the amount of time each Delegate may speak at one time.
8. Separate Assembly time so that resolutions above a certain threshold receive more time for debate, with the remaining time divided between resolutions below the threshold.
9. Create a new, informational category of business for the Assembly that would be reviewed by Standing Committees.
   a. Addendum: Consider adding a separate session where the authors can present informational business.
10. Give delegates points that they can use at the end of the Assembly to prioritize external resolutions.

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<tbody>
<tr>
<td>F1</td>
<td></td>
<td>Recommend</td>
<td>This proposal was submitted as a referendum on existing practice. The RTF indicated interest in investigating other methods to order business, but felt the current order based on quantitative scoring was adequate.</td>
</tr>
<tr>
<td>F2</td>
<td></td>
<td>Do not recommend</td>
<td>Several members of the RTF voiced strong opposition to any sort of cap on the number of resolutions, citing infringement on democratic opportunity and the lack of an objective evaluation system which reliably correlates with quality of the resolution.</td>
</tr>
<tr>
<td>F3</td>
<td></td>
<td>Do not recommend</td>
<td>The discussion on this proposal mirrored F2.</td>
</tr>
<tr>
<td>F4</td>
<td>Creates or furthers opportunities for discussion during the Assembly; Ensures democratic opportunity</td>
<td>Do not recommend</td>
<td>This proposal stems from practice in state assemblies and HOD Reference Committees. While the RTF and the Speakers saw value in the idea, the RTF was not sure that the proposal would bring value worth the implementation.</td>
</tr>
<tr>
<td>F5</td>
<td></td>
<td>Recommend</td>
<td>While the RTF supported the general principle of tracking the outcomes of resolutions important to the MSS, there was discussion that this proposal was not sufficiently defined and could take significant effort and time to implement. Therefore, there is room for the GC to discuss specific implementation. The RTF noted that it might be more effective to track just high-impact resolutions whose outcomes could be distributed for membership and recruiting.</td>
</tr>
<tr>
<td>F6</td>
<td></td>
<td>Do not recommend</td>
<td>There was no discussion in the RTF on this proposal.</td>
</tr>
<tr>
<td>F7</td>
<td>Creates or furthers opportunities for discussion during the Assembly; Ensures democratic opportunity</td>
<td>Do not recommend</td>
<td>The RTF noted that this is already within the purview of the Speakers and felt it best left to their discretion.</td>
</tr>
<tr>
<td>F8</td>
<td></td>
<td>Recommend</td>
<td>This proposal seeks to address the need to protect sufficient time at the Assembly to have thoughtful, high-quality debate on resolutions. With a large volume of</td>
</tr>
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<td>Proposal</td>
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<td>Recommendation</td>
<td>Discussion</td>
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<tr>
<td>resolutions, there is often a desire to speed through earlier items of business so that all resolutions can be discussed at the meeting. This proposal references the fact that the Assembly is under no obligation to complete all items of business on its docket. The RTF supported the idea of giving more time to debate resolutions, though some noted that the scoring rubric which is used to order business does not always correspond with quality. There is room for GC discussion of implementation – for example, implementation of this proposal does not prevent moving on to the next item of business if there is no further discussion, but it may prevent calling the question.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F9</td>
<td>Recommend</td>
<td>This proposal allows individuals to create materials on topics they are passionate about and collaborate with MSS Standing Committees. The RTF clarified that these informational items are presented to the MSS and the items are filed afterward in their own category. The RTF suggested that the presentations might be recorded and posted online after the meeting.</td>
<td></td>
</tr>
<tr>
<td>F10</td>
<td>Do not recommend</td>
<td>The RTF appreciated the aspects of this proposal which increased democratic opportunity in the sense that the prioritization originated from the Assembly. Some noted that this might be useful information for the Section Delegates, though it should not be binding. Others on the RTF argued that the Section Delegates have the responsibility to advocate for all resolutions equally. Therefore the RTF was divided and could not recommend this proposal.</td>
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</table>
CONCLUSION

The RTF identified many challenges faced by authors, reviewers, and staff in the current resolution process, indicating that the resolution process needs to be reformed to ensure that it can continue to produce high-quality resolutions, engage members, foster mentorship, provide equal democratic opportunity, and provide sufficient resources to support external resolutions in the HOD. Throughout its consideration of 49 potential proposals for resolution process reform, the RTF gravitated toward proposals which furthered educational efforts, increased mentorship opportunities, elevated non-resolution avenues for advocacy, and widely distributed resolution feedback across many actors and mediums. The RTF also acknowledged that optimizing the resolution process requires balancing priorities, and therefore the RTF recommended proposals which would alleviate pain points within the process, such as the volume of staff review necessary and Assembly time spent on lower-value discussions such as wordsmithing. The RTF believes that implementation of its recommendations will result in a resolution process which is clearer, fairer, and more valuable for all MSS members.

RECOMMENDATION

The MSS Resolution Process Task Force recommends that the MSS Governing Council consider the following reforms to the resolution process and release a GC Report to the Assembly detailing a pilot implementation of the reforms, and that the remainder of the report be filed.

1. That the MSS invest in further education efforts on the resolution process by:
   a. Training RD/ADs to provide better guidance on the various mechanisms available for advocacy through the AMA and MSS.
   b. Making a video explaining the basics of Parliamentary Procedure and the most common mistakes made.

2. That the MSS elevate the stature of non-resolution avenues for advocacy by:
   a. Publicizing GC Action Item Requests widely and increase the prestige of these proposals.
   b. Creating a new, informational category of business for the Assembly that would be reviewed by Standing Committees, which could be presented in a separate programming session where the authors present informational business.
   c. Providing a formal document to its members as proof of significant, non-resolution-related work which they can provide as support for a conference funding and time-off request. Examples of significant, non-resolution-related work include serving as a Delegate or on a Committee.

3. That the MSS encourage mentorship between its members and throughout the AMA by:
   a. Creating an indicator on the Open Forum that shows if the originator is a first-time author. This visibility would allow more experienced writers to help the new authors and mentor them through the process.
   b. Requiring all external resolution authors to contact the relevant specialty society prior to submission.

4. That the MSS improve transparency of resolution feedback among all actors throughout the resolution process by:
   a. Requiring the GRAF, MSS Councilor on Legislation, Section Delegations, and Region Delegation Chairs to analyze the Open Forum for resolutions that the AMA Federal Advocacy Office would be interested in reviewing.
   b. Broadening the functional scope of the HCC so HCC members can contact Region leaders to improve resolutions that would otherwise likely be reaffirmed.
c. Requiring primary reviewers to send feedback summary emails to the primary author’s Region Chair and Region Delegation Chair in order to allow Regions to incorporate draft feedback into their Region authorship voting if they choose to.
d. Requesting that HCC post a summary of their comments from the draft review process to the VRC.
e. Requesting that RD/ADs provide meaningful testimony on the VRC for resolutions they reviewed, especially in cases where important recommendations were not considered.

5. That the MSS streamline existing procedures in the resolution process by:
   a. Coordinating Region resolution authorship/support through a central AMA email process so more medical school sections can be reached.
   b. Giving the HOD Coordination Committee responsibility to review all submissions and place items on a Reaffirmation Consent Calendar. Items on the Reaffirmation Consent Calendar will not receive detailed staff review except analysis from Legal Counsel.
   c. Adjusting resolution deadlines to allow more time for review between the final submission and VRC.

6. That the MSS change its scoring rubric to:
   a. Reaffirm its existing rubric categories of authorship, clarity, research quality, scope, feasibility, novelty, addressing the MSS Policy Objectives, thoughtful response to feedback, and scoring on a quantitative scale.
   b. Eliminate the existing rubric category of addressing the AMA Strategic Focus Areas.
   c. Not include scoring of the fiscal note as a rubric category.

7. That the MSS reaffirm its existing process of creating the Assembly’s Order of Business according to quantitative resolution scores.

8. That the MSS create and further opportunities for high-quality discussion in the Assembly by:
   a. Creating a new Reference Committee recommendation category named “recommend for GC action item.”
   b. Separating Assembly time so that resolutions above a certain threshold receive more time for debate, with the remaining time divided between resolutions below the threshold.

9. That the MSS improve continuity of its advocacy efforts from meeting to meeting by:
   a. Requiring authors of external resolutions to sign a virtual acknowledgement agreeing to help the Section Delegates and Regional Delegates in bringing their resolution to the AMA HOD, if their resolution is passed by the Assembly.
   b. Providing a report after each Assembly meeting on the impact of the resolutions passed.
   c. Giving the Section Delegates responsibility for conducting an annual survey which sets the MSS Policy Objectives for the given year.
Appendix A. MSS Resolution Process Task Force Charter

MSS Resolution Process Task Force

Background

At the 2017 Interim Meeting of the AMA Medical Student Section (MSS), the Assembly received an unprecedented number of resolutions for discussion and evaluation. 194 ideas were posted on the Open Forum, 124 draft resolutions were submitted, and 95 final resolutions were accepted as business of the Assembly. During the Assembly Meeting, 35 resolutions were extracted from the reference committee calendar and 33 resolutions were discussed. At the conclusion of the meeting, 33 external resolutions were passed for forwarding to the House of Delegates, of which 2 were immediately forwarded and 31 will be forwarded at the 2018 Annual Meeting.

The MSS Governing Council (GC) welcomes the increased interest in our MSS policy process and Assembly, and encourages students to submit resolutions advocating on issues which are important to them. However, several stakeholders have raised concerns about a possible upward trend in resolution submissions. These concerns include:

1. The number of resolutions submitted may exceed the capacity of the current system and place undue burden on AMA staff, the MSS Delegates, and members involved in the resolution process such as RDs, ADs, HCC, and standing committees.
2. The volume of resolutions accepted for business of the assembly may not allow delegates to adequately prepare for the Assembly, and it may not allow for substantive discussion during the Assembly due to the desire to discuss all items of business.
3. The current resolution process may not provide sufficient evaluation and mentorship of resolution ideas and drafts, leading to a high proportion of resolutions that are reaffirmed or not adopted.

Task Force Charter

The MSS GC recognizes the importance of finding an equitable and democratic solution to address these issues. As such, the MSS GC is forming an MSS Resolution Process Task Force with representation from all of our regions and stakeholders to assess the current process and to make recommendations to the MSS GC on potential improvements that may address the current concerns. Based on the Task Force’s recommendations, the MSS GC will produce a GC report to the Assembly for the 2018 Annual Meeting proposing changes to the MSS policy process through amendments to the MSS Internal Operating Procedures.

The charge to the MSS Resolution Process Task Force is to:

2. Assess the effectiveness of our current resolution process in achieving its goals, including:
   a. Producing high-quality resolutions worthy of discussion at our MSS Assembly
   b. Engaging our members with mentorship and discussion
   c. Providing an equal democratic opportunity to be heard
   d. Giving every external resolution passed by the Assembly sufficient resources to advocate for passage in the HOD
3. Collect and evaluate information on the impact of our current process on the various stakeholders in our process, including:
   a. MSS Assembly
   b. MSS Delegates
   c. MSS House Coordinating Committee and the MSS Caucus
   d. MSS staff
   e. AMA advocacy staff and policy experts
   f. The AMA House of Delegates
   g. AMA HOD specialty society delegations

4. Recommend actions and efforts that would have a meaningful positive impact on the major resolution process concerns:
   a. Insufficient time for adequate discussion of resolutions in the Assembly
   b. Impact on student leadership (incl. sectional and regional delegates as well as HCC)
   c. Impact on AMA staff (incl. MSS staff and non-MSS experts)
   d. Number of external resolutions forwarded to HOD


Task Force Composition

The MSS Resolution Process Task Force shall have the following composition:

Co-Chairs:
Helene Nepomuceno, MSS Chair (non-voting)
Karthik V. Sarma, MSS Trustee (non-voting)

Members:
Joy Lee, MSS Councilor on Constitution and Bylaws (Task Force secretary, voting)
Jerome Jeevarajan, MSS Delegate (voting)
Kieran McAvoy, MSS Alternate Delegate (non-voting alternate)
Region 1 Representative (voting)
Region 1 Alternate (non-voting alternate)
Region 2 Representative (voting)
Region 2 Alternate (non-voting alternate)
Region 3 Representative (voting)
Region 3 Alternate (non-voting alternate)
Region 4 Representative (voting)
Region 4 Alternate (non-voting alternate)
Region 5 Representative (voting)
Region 5 Alternate (non-voting alternate)
Region 6 Representative (voting)
Region 6 Alternate (non-voting alternate)
Region 7 Representative (voting)
Region 7 Alternate (non-voting alternate)

Region representatives shall be appointed by Region Chairs with the advice of their Region Governing Council members. Regions are advised to appoint representatives with familiarity
with both the MSS resolution process and the AMA House of Delegates, such as former or current members of the MSS House Coordinating Committee or the MSS Caucus. In order to ensure adequate representation, absences from Task Force meetings shall be reported to region boards at the conclusion of every meeting, and region chairs may choose to replace members who are unable to attend. Meetings of the Task Force will be scheduled and facilitated by the non-voting co-chairs, who shall maintain impartiality in all Task Force proceedings. The MSS Speakers will also be invited as permanent guests in order to answer any questions regarding the Assembly process, but will not otherwise be participating members of the Task Force. The following is a non-exhaustive list of recommended AMA staff interviewees:

Haley Guion, JD, Director, Medical Student Section
Hannah Handal, Policy Analyst, Medical Student Section
George Cox, JD, Director, Legislative Counsel
William Estes, Government Relations Advocacy Fellow

Task Force Meetings

The Task Force is expected to meet five times via conference call to interview guests and facilitate discussion. The estimated duration of each meeting is two hours. In order to align with the requirements in the MSS Assembly for IOP changes, the final recommendations will require the approval of 2/3 of voting members to be forwarded to the MSS Governing Council. In the event that a voting member is not present, the member’s designated alternate may vote in his or her place.

The Task Force Secretary will, in consultation with the Co-Chairs, prepare minutes of every Task Force meeting, which will be published for MSS Assembly viewing after approval by the Task Force. In order to facilitate open discussion, minutes will be de-identified before release. Task Force meetings will be closed, but the Task Force shall have the power to invite guests and observers to one or more of its meetings at its discretion in order to provide required information.
Appendix B. MSS Annual Meeting 2018 Resolution Scoring Rubric

MSS Annual Meeting 2018 Resolution Scoring Rubric

Authorship (5 points)
This will be assigned by the MSS Delegate/Alt Delegate (see spreadsheet). Was this resolution authored on behalf of an entire Section (3 points), State (4 points), or Region (5 points)? Otherwise, 0 points awarded. RDs, ADs, and HCC members: please award full credit.

Clarity (10 points)
Are the Whereas clauses succinctly stated and do they clearly support the requested action of the Resolved clauses? Do the Whereas clauses create a logical, coherent argument flowing naturally to support the Resolved clauses? Do none, some, or all of the Whereas clauses support the Resolved clauses? Do any Whereas clauses leave you with questions about the issue or about the argument?

Research (30 points)
How many total references, and are they from appropriate authorities on the subject matter? Are none, some, or all of the references from trustworthy, high quality, evidence-based sources (e.g. peer-reviewed journals, respected news sources)? Are none, some, or all from the past 5 years? Are none, some, or all of the factual assertions in the Whereas clauses supported by sufficient evidence?

Scope & Feasibility (25 points)
Does this resolution address a new, broad principle that will be applicable to multiple issues OR does it address a specific, current, actionable and timely issue? Is the resolution feasible, appropriate, and within the general scope of issues for the AMA (external) or AMA-MSS (internal) to address?

Novelty (15 points)
Does this resolution address a subject matter largely neglected by current policy; add in a valuable way to existing policy; or is a departure/in opposition to current AMA policy or AMA-MSS policy?

Focus (10 points)
Do the Resolved clauses address one or more principles of the AMA’s Strategic Focus OR the MSS’ Internal Policy Objectives (IPOs)? (Scoring from the MSS Delegate/Alt Delegate will also be included in this average)

Fiscal Note (10 points)
Is the fiscal note high? Did the authors amend language to decrease fiscal note? (Please see Fiscal Note Rubric for further information)

AMA Strategic Focus: (a) Improving health outcomes, (b) Accelerating change in medical education, (c) Professional satisfaction and practice sustainability.

MSS Internal Policy Objectives (IPOs): (1) Pursuing innovative mechanisms to improve medical student wellness and mitigate burnout; (2) Cultivating the delivery of equitable healthcare to diverse patient populations in a dynamic environment, including via the promotion of diversity within the medical profession; and (3) Addressing emergent public health threats with impactful and evidence-based solutions.

Response to Feedback (5 points)
Did the authors respond to scoring and feedback in a way that demonstrated their appreciation for the critiques? For full credit, authors need not necessarily change their resolution, but their responses to feedback must indicate that they have thought through and anticipated objections to their resolution. RDs, ADs, and HCC members: please award full credit.
<table>
<thead>
<tr>
<th>Authorship*</th>
<th>0 (Whereas clauses do not support Resolved clauses; difficult to follow argument)</th>
<th>3 (Section)</th>
<th>4 (State)</th>
<th>5 (Region)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarity</td>
<td></td>
<td>5 (Some arguments are missing to support the Resolved clauses; argument is unclear at times)</td>
<td>10 (Whereas clauses clearly support the Resolved clauses; argument clear and logical)</td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td>0 (None of the Whereas clauses are supported by recent, appropriate sources)</td>
<td>5-10 (Less than half to few whereas clauses are supported by recent, appropriate sources)</td>
<td>15 (Half of the Whereas clauses are supported by recent, appropriate sources)</td>
<td>20-25 (Most to nearly all Whereas clauses have sufficient, appropriately sourced evidence)</td>
</tr>
<tr>
<td>Scope &amp; Feasibility</td>
<td>0 (too specific; not timely or actionable; likely infeasible and clearly not within AMA or MSS purview)</td>
<td>5 (specific and minimally timely or actionable; questionably feasible, and unlikely to be within AMA or MSS purview)</td>
<td>10-15 (specific but somewhat timely and actionable; questionably feasible; may not be within AMA or MSS purview)</td>
<td>20 (broad in scope, or specific but timely and actionable; questionably feasible but clearly within purview)</td>
</tr>
<tr>
<td>Novelty</td>
<td>0 (completely covered by existing policy)</td>
<td>5 (largely covered by existing policy)</td>
<td>10 (less significant change to existing policy)</td>
<td>15 (new subject matter or significant departure from existing policy)</td>
</tr>
<tr>
<td>Focus</td>
<td>0 (does not address any strategic principle or IPO)</td>
<td>5 (loosely addresses strategic principle or IPO)</td>
<td>10 (clearly addresses strategic principle or IPO)</td>
<td></td>
</tr>
<tr>
<td>Fiscal Note</td>
<td>0 (high fiscal note)</td>
<td>5 (medium fiscal note)</td>
<td>10 (low fiscal note)</td>
<td></td>
</tr>
<tr>
<td>Response to feedback*</td>
<td>0 (assessed by Section Delegates)</td>
<td>5 (assessed by Section Delegates)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
*RDs, ADs, HCC members: please give full credit
<table>
<thead>
<tr>
<th>AMA-MSS Fiscal Note Rubric</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Point Range</strong></td>
</tr>
<tr>
<td><strong>Minimal</strong></td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
</tr>
<tr>
<td><strong>Significant</strong></td>
</tr>
<tr>
<td>+/- 1 for alignment*</td>
</tr>
</tbody>
</table>

*Alignment point dependent on alignment with strategic focus areas and IPO’s*
Appendix C. Modified AMA Medical Student Section A-18 Resolution Guide

AMA Medical Student Section A-18 Resolution Guide

The AMA-MSS Resolution Guide serves as a resource to help you craft and submit a resolution. Resolution authors are required to complete the tasks described below. Resolutions will not be considered “received” until all required tasks indicated in both the draft and final resolution checklists have been initialed and completed.

Questions? Please contact the AMA-MSS Delegate, the AMA-MSS Alternate Delegate, or the AMA-MSS Policy Analyst.

Dates and Deadlines* for Resolution Authors
MSS Annual Meeting 2018
*All deadlines expire at 11:59 PM PST except for VRC Open/Close time

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 18 (Sun)</td>
<td>Deadline to post ideas on <a href="#">MSS Open Forum</a></td>
<td>Deadline for authors to share ideas with Region Delegation Chair</td>
</tr>
<tr>
<td>March 28 (W)</td>
<td>Draft resolutions and checklists due</td>
<td>Must upload using <a href="#">A-18 Resolution Draft Submission Form</a></td>
</tr>
<tr>
<td>April 4 (W)</td>
<td>Preliminary scoring and comments on draft resolutions released to authors</td>
<td></td>
</tr>
<tr>
<td>April 11 (W)</td>
<td>Final resolutions and checklists due</td>
<td>Must upload using <a href="#">A-18 Resolution Final Submission Form</a></td>
</tr>
<tr>
<td>April 23 (M)</td>
<td>Virtual Reference Committee (VRC) Opens at 12:00PM PST</td>
<td></td>
</tr>
<tr>
<td>May 11 (F)</td>
<td>Virtual Reference Committee (VRC) Closes at 12:00PM PST</td>
<td></td>
</tr>
<tr>
<td>May 22 (T)</td>
<td>Reference Committee Report released</td>
<td></td>
</tr>
<tr>
<td>June 7-9</td>
<td>2018 National Medical Student Annual Meeting</td>
<td></td>
</tr>
</tbody>
</table>

Region Delegation Chairs

Region 1-
Region 2-
Region 3-
Region 4-
Region 5-
Region 6-
Region 7-
Researching Your Resolution

1. Authors must ensure that an MSS resolution is the best means of accomplishing their goals. The following are common examples of issues that are NOT best addressed through an MSS resolution:

   The resolution addresses an issue that could be resolved by the AMA-MSS Governing Council, specifically by submitting a GC Action Item request.

   The resolution addresses a medical school-specific issue that would be more appropriately addressed by medical school faculty or administration.

   The resolution addresses a specialty-specific issue that would be more appropriately addressed by the relevant medical specialty society.

   The resolution addresses a state-specific issue that would be more appropriately addressed by a state medical society.

   The resolution addresses an issue that is already sufficiently covered by existing AMA Policy or existing AMA-MSS Policy.

1. Resolutions that succeed in the MSS are well-researched and novel, and add value to the policy compendiums of the AMA or AMA-MSS. Authors must understand what has been attempted and accomplished in the past in order to produce strong resolutions for the future.

   Review the AMA Strategic Focus Areas and MSS Internal Policy Objectives to understand the priority issues for our organization (see scoring rubric below).

   Review existing AMA Policy and existing AMA-MSS Policy.

   Review the Proceedings from past years’ MSS meetings for examples of what policy proposals have and have not been successful in its Assembly.

   Review past House Coordination Committee Executive Summaries of items in which the MSS had a vested interest and stance on in the House of Delegates.

Writing Your Resolution

1. Use the Resolution Template! (New for A-18!)

2. Follow the resolution formatting guide.

3. For external resolutions (those that call for the AMA to act, not the AMA-MSS), understand that the burden on the authors to do their due diligence in research, soliciting appropriate feedback and making appropriate contacts is more rigorous than for internal resolutions. Authors of external resolutions should ensure that their topic is appropriate for external submission and aligns with AMA’s Strategic Focus Areas:

   d. Improving Health Outcomes
   e. Accelerating Change in Medical Education
   f. Enhancing Physician Satisfaction and Practice Sustainability by Shaping Delivery and Payment Models.
3. For external resolutions, authors should be aware that if their item should pass, it will not be brought forward to the AMA House of Delegates until the following national meeting. However, authors must be prepared to complete the following:

   a. Work with the AMA-MSS Delegate and Alternate Delegate in advance of the following national meeting in order to help in the passage of their item, including submitting written testimony in support of the item.

4. For external resolutions that call for immediate forwarding to the House of Delegates following the same MSS meeting at which they are passed authors must be aware that:

   a. Only in rare cases are resolutions forwarded immediately to the HOD.
   b. There must be unusual circumstances deserving of immediate consideration by the HOD assembly.
   c. The MSS Delegate and Alternate Delegate must be contacted regarding the author's intentions well in advance of the actual meeting.
   d. Authors must submit written testimony to the MSS Delegate and Alternate Delegate for submission to the HOD.
   e. Authors must attend the MSS caucus Saturday afternoon/evening in order to help with strategy for passage of their resolution.

5. Note about withdrawal of resolutions:

   a. All submitted final resolutions will become the business of the MSS Assembly on April 20th at 11:59 PM PST. Primary authors will have the opportunity to withdraw their resolutions if desired before this deadline.
Appendix D. Proposals Considered by the RTF, Organized by Stage

A. Education and Infrastructure

1. Train RD/ADs to provide better guidance on the various mechanisms available for advocacy through the AMA and MSS.
2. Create a formal document and/or talking points to provide to members as proof of significant, non-resolution related work (i.e. serving as a Delegate, in leadership, on a committee, etc.) which they can provide as support for a conference funding and time-off request.
3. Make a video explaining the basics of Parliamentary Procedure and the most common mistakes people make.
4. Create a PolicyFinder for AMA-MSS policy to replace the current PDF.
5. Publicize GC Action Item Requests widely and increase the prestige of these proposals. For example, requesters can present GC Action Item Requests during a programming session.
6. Define an individual on each Region GC whose can be contacted by other Regions to collaborate during the resolution process.

B. Brainstorming Stage (Pre-Draft Submission)

1. Have a MSS leader analyze the Open Forum for resolutions that the AMA Federal Advocacy Office would be interested in reviewing. The MSS leader will give a preliminary ranking and recommendation to each idea (similar to HCC). They will then forward the list and assessments on to the GRAF, who will determine which ones elevate to the level of staff input.
   a. MSS leader could be the student COL member or the Section Delegates and Region Delegation Chairs.
2. Have the GRAF monitor the Legislation and Advocacy subfolder on the Open Forum.
3. Have students submit resolution ideas to Regional leadership (e.g. the policy chair), who will then post the idea to the proper Open Forum category.
4. Have an indicator on the Open Forum that shows if the originator is a first-time author. This visibility would allow more experienced writers to help the new authors and mentor them through the process.

C. Revision Stage (Post-Draft Submission, Pre-Final Submission)

1. Emphasize feedback on resolutions that do not receive State or Regional support, e.g. ask Regions to submit formal reasoning behind why they chose NOT to support a policy, or having additional reviewers on single-author resolutions.
2. Broaden the functional scope of the HCC so HCC members can contact Region leaders to improve resolutions that would otherwise likely be reaffirmed.
3. Make HCC review summaries easily available in a compiled report.
4. Primary reviewers must send feedback summary emails to the primary author’s Region Chair and Region Delegation Chair in order to allow Regions to incorporate draft feedback into their Region authorship voting if they choose to.
5. All external resolutions are required to have Region authorship.
   a. Addendum: Regions are capped at supporting 5 external resolutions written primarily by their own members.
6. All external resolutions must have cross-regional authorship.
7. All external resolution authors must contact the relevant specialty society prior to submission.
8. All resolutions must have cross-regional authorship.
9. Coordinate Region resolution authorship/support through a central AMA email process so more medical school sections can be reached.

10. All members of the MSS Caucus (RDs/ADs + state ADs) vote on whether they believe the resolution should be considered at the Assembly, and only resolutions above some threshold are allowed to advance to the final resolution phase.

11. Upon submission of a final draft, having authors of external resolutions virtually sign an acknowledgement saying that they understand that, if passed, that their resolution will be forwarded to the AMA HOD at the subsequent meeting and that they will help the Section Delegates and MSS RD/ADs in bringing their resolution to the AMA HOD. This would include but not be limited to updating whereas clauses for the next meeting with the most up to date literature, crafting testimony for the VRC and live Reference Committee hearings, and reaching out to specialty societies.

D. Scoring Stage

1. Resolutions should be scored based on authorship (section, state, region).
2. Resolutions should be scored based on clarity.
3. Resolutions should be scored based on research quality.
4. Resolutions should be scored based on scope.
5. Resolutions should be scored based on feasibility.
6. Resolutions should be scored based on novelty.
7. Resolutions should be scored based on how well they address AMA Strategic Focus Areas.
8. Resolutions should be scored based on how well they address MSS Policy Objectives.
   a. The Section Delegates should be responsible for conducting an annual survey which sets the MSS Policy Objectives for the given year.
   b. A resolution’s score of how well it addresses MSS Policy Objectives should make up a larger proportion of the overall score (currently 10%).
9. Resolutions should be scored based on whether they responded to feedback.
10. Resolutions should be scored on a quantitative scale.
11. Resolutions should be scored with consideration of their fiscal note.

E. VRC/Reference Committee Stage

1. Create a new Reference Committee recommendation category named “recommend for GC action item.”
2. Adjust resolution deadlines to allow more time for review between the final submission and VRC.
3. Release the list of final resolutions prior to VRC opening so that regions and states will have more time to organize their resolution review processes.
4. Have HCC post a summary of their comments from the draft review process to the VRC.
5. After final resolutions are submitted, the HOD Coordination Committee (HCC) will review all submissions and place items on a Reaffirmation Consent Calendar based on simple majority voting within the Committee. The selected items will not receive detailed staff review except analysis from Legal Counsel. The selected items will be displayed on the Virtual Reference Committee as “Reaffirmation Consent Calendar” separate from the Resolutions folder and Reports folder. The Reaffirmation Consent Calendar will be open for comments on the VRC but will not be business of the MSS Assembly unless extracted during the MSS Assembly Opening Session.
6. Have RD/ADs provide meaningful testimony on the VRC for resolutions they reviewed, especially in cases where important recommendations were not considered.
7. Conduct debate on lower scoring resolutions in a live forum where people can vote ahead of the Assembly. The vote can eliminate resolutions before the Assembly.

F. Assembly Stage

1. Create the Assembly’s Order of Business according to resolution scores.
2. Cap the number of resolutions for discussion at the Assembly.
3. Cap the number of resolution that can be forwarded to the HOD from each Assembly.
4. Designate specific microphones as PRO, CON, and repeat speaker microphones.
5. Provide a report after each Assembly meeting on the impact of the resolutions passed.
6. Establish a threshold vote required to extract a resolution.
7. Place a time limit on discussion for each resolution or on the amount of time each Delegate may speak at one time.
8. Separate Assembly time so that resolutions above a certain threshold receive more time for debate, with the remaining time divided between resolutions below the threshold.
9. Create a new, informational category of business for the Assembly that would be reviewed by Standing Committees.
   a. Addendum: Consider adding a separate session where the authors can present informational business.
10. Give delegates points that they can use at the end of the Assembly to prioritize external resolutions.
Appendix E. Resolution Alternatives

Resolution Alternatives

Prior to drafting a resolution, all potential authors should contact their Regional Delegate to determine whether a resolution is the best course of action. Sometimes it may not be necessary or appropriate to submit a resolution to the AMA-MSS Assembly for consideration. Alternatives include:

1. Submitting a request for action to the AMA-MSS Governing Council
2. Researching work being done by other medical societies or health care groups
3. Working with state and county medical societies
4. Working with the administration or other leaders at your medical school
5. Co-authoring a resolution that someone else is submitting

Consider the following situations in which writing a resolution might not be the most efficient way of addressing the issue.

Situation 1: AMA policy exists, but there has not been much action.

Students are encouraged to submit a request for action to the Governing Council if there is an issue addressed by existing policy that needs follow up. Students should provide the Chair with background information about the issue, the AMA or MSS policy that covers action on the issue, and the proposed action that should be taken. It is important to note that the AMA and MSS face limited financial and time resources, so it may not be possible to follow up with every policy request. Similarly, though, it would not be possible to implement every new policy created by a new resolution in a thorough and meaningful way.

Situation 2: General AMA policy exists, but a specific issue needs attention.

Strong policies support general principles that can be applied across a variety of similar circumstances. In cases where general policy exists, but a specific issue demands action, MSS members are encouraged to bring these issues to the attention of the MSS Governing Council so that appropriate follow-up action may be taken. Such action may include encouraging the AMA to prepare a letter in support of a specific piece of legislation, disseminating existing information to medical school section leaders to educate their peers, or working with the AMA to publicize our position on a certain issue.

Situation 3: The issue is important, but may be best approached by another organization or entity.

The AMA is a great venue for creating change, however some topics may be best approached by another organization or entity. In many cases we are not the appropriate group, or we do not possess the influence or expertise necessary to pursue the issue. In other cases, limited resources require the AMA-MSS to focus its energy on issues of national importance to medical students, rather than on issues of more limited scope. It is critical that, within the MSS, we acknowledge
AMA-MSS Fiscal Note Rubric

<table>
<thead>
<tr>
<th>Expertise Available</th>
<th>No. Of Departments Involved</th>
<th>Timeline Requirement</th>
<th>Does Resolution Require Financial Resources?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal (1pt)</td>
<td>Knowledge is readily available</td>
<td>MSS Only</td>
<td>A month or less</td>
</tr>
<tr>
<td>Moderate (2pt)</td>
<td>Requires some research</td>
<td>2-4</td>
<td>Multiple months</td>
</tr>
<tr>
<td>Significant (3pt)</td>
<td>Requires dedicated research</td>
<td>5+</td>
<td>Over a year</td>
</tr>
</tbody>
</table>

**Point Range**

<table>
<thead>
<tr>
<th>Level</th>
<th>Range</th>
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</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>4-6</td>
</tr>
<tr>
<td>Moderate</td>
<td>6-10</td>
</tr>
<tr>
<td>Significant</td>
<td>10-12</td>
</tr>
</tbody>
</table>

+/- 1 for alignment*

*Alignment point dependent on alignment with strategic focus areas and IPO’s
Throughout the A-18 AMA-MSS resolution review process, the MSS House of Delegates Coordination Committee (HCC) provided input to help medical student authors and reviewers. First, HCC provided policy reviews for every idea that was posted on the A-18 Open Forum platform. These policy reviews consisted of a simple list of current AMA and AMA-MSS policy so that authors were aware of all the relevant policy that already existed in their area of interest. These policy reviews were posted as comments on each post within 5 days after the close of the A-18 Open Forum.

After resolution drafts were submitted, one HCC member was assigned to each resolution draft. They provided another policy review at this time and communicated their thoughts via Google Docs commentary. HCC members took note of any resolution drafts that appeared to have Resolve clauses that were very similar to existing AMA and/or AMA-MSS policy. HCC performed this review during the same time period that Region Delegates and other medical student reviewers were reviewing the draft resolutions.

After final resolutions were submitted, the MSS Policy Analyst prepared a combined PDF of all the final resolution drafts and sent them to HCC. Then the committee held a conference call to discuss and make final recommendations as to which resolutions could be effectively covered by existing AMA and/or AMA-MSS policy. Each recommendation was decided by a majority of HCC members who were present on the call. A list of final recommendations, titled "HCC Reaffirmation Calendar," was to the Policy Analyst three days prior to the opening of the MSS Virtual Reference Committee. This process was accomplished successfully when there were 12 days between the final resolution submission deadline and the opening day of the MSS VRC. Resolutions on this list did not receive as extensive of a background review and were also labeled on the MSS VRC with the phrase "ON REAFFIRMATION CALENDAR." Lastly, HCC provided a written statement of their rationale including cited MSS and AMA policies to the MSS Reference Committee members who will make the final recommendations in the A-18 Reference Committee report.
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. The final report and its recommendations will serve as the basis for extraction, discussion, and voting at the onsite Assembly Meeting.
Submission:

Submitted by Sophie Chung on Tue, 03/13/2018 - 23:09

Title:
Opioid Use Disorder Education for Medical Students and Residents

Short Summary of the Problem/Issue:
Despite the growing impact of the opioid epidemic, appropriate training for medical students and residents has not kept pace with the crisis.

An inadequate number of trainees are taught how to administer Naloxone, and only physicians with a Drug Enforcement Administration (DEA) waiver can prescribe OUD treatments such as buprenorphine-naloxone (Suboxone). While students are now often taught to use Naloxone in acute overdose encounters, education has not adequately incorporated other long-term treatments for OUD or prevention of future overdoses.

The number of DEA-licensed physicians is inadequate to meet demand, as indicated by the proposal to increase their patient “caps.” Given that misused prescription opioids were an entry point for 80% of heroin users, clinicians and future trainees are the first line of defense against the opioid epidemic. Moreover, several medical schools have successfully incorporated pilot programs in buprenorphine training.

Action Requested:
That our AMA-MSS ask the Board of Trustees to:
1) Supports the implementation of buprenorphine and other opioid use disorder treatment training into medical student and resident curricula in concordance with DEA regulations, allowing them to incorporate OUD treatment into future practice
2) Lowers the cost of training to reduce the barrier to entry for medical students and residents

Supporting Policies:
D-95.987, D-120.985, D-160.981; H-95.954; H-95.957, H-310.906, H-515.956

First Name:
Sophie

Last Name:
Chung

Email:
sophie.chung@yale.edu
Caregiving youth are minors who are responsible for medical and personal care and household responsibilities when a family member is ill, elderly or disabled. The responsibilities include but are not limited to suctioning and tube feedings, medication administration and management, bathing, feeding, toileting, household chores and parenting of siblings. Children in single parent and low-income families are most impacted.

The only national statistics (2005) indicate that there are at least 1.3 to 1.4 million caregiving youth ages 8-18 years in the United States. Juggling caregiver and student roles has led to increased depression and anxiety in caregiving youth compared to non-caregiving peers. Furthermore, 22% of young adults who dropped out of school did so to care for a family member (2006). The recent National Caregiving Alliance/AARP caregiver survey and White House Conference on Aging (2015) do not include caregivers below age 18, indicating a continuing lack of awareness.

I ask our AMA to encourage the Office of Adolescent Health to collaborate with the Family Caregiver Alliance and the American Association of Caregiving Youth to provide the appropriate support services for caregiving youth. I ask our AMA to specifically define these caregivers as “caregiving youth” since current research defines this population as “caregiving youth”. To increase awareness, I request the AMA to encourage caregiving researchers to incorporate inclusion criteria that include caregiving youth in their samples or survey questions. I also request that the AMA work with the American Academy of Family Physicians and the American College of Physicians to encourage physicians to write summative articles in their respective professional journals that reflect on current caregiving youth research and how primary care physicians can support caregiving youth. I ask that our AMA encourage physicians to screen families at the time of diagnosis to determine who will become the caregiver.

Physicians and Family Caregivers: Shared Responsibility H-210.980

Physicians and Family Caregivers - A Model for Partnership:
H-210.981

First Name:
Brian

Last Name:
Liang

Email:
briliang@uchc.edu
Binge drinking and alcohol use disorder are significant concerns in the U.S., with over % of U.S. adults admitting to binge drinking. Excessive consumption contributes to the death of 88,000 Americans every year and is associated with addiction, obesity, and many other chronic health concerns. Despite FDA-required requiring nutrition labeling of food and beverages, most alcoholic beverages are not required to display nutritional information. Recently, the “Brewers’ Voluntary Disclosure Initiative” was begun to encourage brewers to include nutrition facts and ingredients on their packaging. While this is a step in the right direction for transparency, this initiative is voluntary and only encompasses beer products. Mandating nutrition labeling for all alcohol products would bring the alcohol industry in line with the food industry regulations, which will empower consumers to make informed decisions about their alcohol consumption, helping to combat this public health issue.

Action Requested:

The AMA has policy encouraging labeling of alcoholic beverages (see below), but I am unsure what has been done recently to advocate for this policy. I believe it would be helpful for the AMA-MSS to look into what advocacy is being done by the AMA at this time on this subject. If nothing, the AMA-MSS should ask the AMA Board of Trustees to take action to revitalize advocacy for this subject, which can take many forms such as lobbying or publicizing the issue via media.

Supporting Policies:

AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages H-30.940

SPECIFICALLY:
(d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.

First Name:  
Taylor

Last Name:  
Boland

Email:  
taylor.boland3@gmail.com
Submitted by Anonymous on Mon, 05/21/2018 - 01:12

Title:
Investigate Options for Responding to Reinstatement of the Abortion Gag Rule

Short Summary of the Problem/Issue:
The New York Times, NPR, and other major outlets have reported that the Trump administration plans to imminently reinstate the domestic abortion gag rule, which would require facilities receiving federal family planning funds to be physically separate from those that perform abortion, eliminate the requirement that women with unintended pregnancies be counseled on their full range of reproductive options, and ban abortion referrals. This move follows the administration's decision early last year to revive the global version of the gag rule, requiring international NGOs receiving US foreign aid to certify that they do not perform abortions, discuss them with their patients, or advocate for the liberalization of abortion laws, even with their non-US funds. Though many US and international health organizations issued statements condemning this move, the AMA remained silent. The MSS and the AMA have clear policy opposing this kind of interference in the doctor-patient relationship.

Action Requested:
The MSS should approach the AMA Board of Trustees and determine whether they plan to issue a statement in the event that the domestic gag rule is imposed. Unless provided a sufficiently compelling explanation why the AMA should remain silent, the Section should ask the Board to publicly oppose this and any interference in the content of the communication between doctor and patient, both domestically and abroad.

(If it is possible, a response back regarding the Board's anticipated position before the MSS meeting would be greatly appreciated in case interested parties would like to submit a Late Resolution on this matter.)

Supporting Policies:
MSS Policy
270.004 MSS Policy on the "Gag Rule"

AMA Policy

AMA Code of Medical Ethics
1.1.1 Patient-Physician Relationships
1.1.3 Patient Rights
11.2.4 Transparency in Health Care

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Submission:

Submitted by Anonymous on Sun, 07/30/2017 - 19:41

Title:
Cybersecurity Tools

Short Summary of the Problem/Issue:
Many of our healthcare facilities across the country are subjected to cyber-attacks and few have the complete array of cybersecurity tools necessary to fight off the most sophisticated of attacks. We've recently seen an increase in the number of ransomware attacks in which digital files from PHI to radiology reports have been locked and held for a virtual ransom leading to delays in patient care and potential loss of patient confidentiality. As the AMA, we represent a wide array of providers in various delivery models; some are employees of big hospitals that have large IT departments while some have their own practice or work for a small-scale facility that doesn't necessarily have the IT resources to be ready to prevent the next cyber-attack. We as the AMA should provide the newest possible educational resources to help providers be more knowledgeable about tips and strategies to not fall prey to a ransomware attack.

Action Requested:
We as the AMA-MSS should ask the Board of Trustees to approve the creation of a set of tips & strategies to preventing cyberattacks (including ransomware) and what to do/not to do in case of an attack. These resources should be specifically guided towards those in small practices with limited IT support staff. We need to act on existing policy to help our members prepare for and prevent ransomware attacks.

Supporting Policies:
315.006MSS Improving Cybersecurity in Healthcare Facilities: AMA-MSS supports the development of new cybersecurity resources for providers that go beyond HIPAA compliance in order to adequately protect patient health information against new cybersecurity threats, such as ransomware, as they emerge. (MSS Res 07, I-16)

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