AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION (A-18)

Report of MSS Reference Committee

Celeste Peay, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1) Resolution Task Force Report 01- Reforms to the Resolution Process: Recommendations from the MSS Resolution Task Force
2) Committee on Long Range Planning Report A- Study the Motivations Behind Resolution Writing
3) Resolution 20- Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle
4) Resolution 46- Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing

RECOMMENDED FOR ADOPTION AS AMENDED

5) Governing Council Report A – Pilot Implementation of the 2018 Resolution Task Force Recommendations
6) Resolution 01- Opposition to Regulations That Penalize Immigrants For Accessing Health Care Services
7) Resolution 03- Expansion of Federal Gun Restriction Laws to Include Dating Partners and Convicted Stalkers
8) Resolution 13- Addressing Student Debt in Medical School Attrition Due to Mental Illness
9) Resolution 15- Support for Continued 9-1-1 Modernization and the National Implementation of Text-to-911 Service
10) Resolution 16- Opposition to Armed Campuses
11) Resolution 18- Increasing the Legal Age of Purchasing Ammunition and Firearms from 18 to 21
12) Resolution 19- Support Offering HIV Post Exposure Prophylaxis To All Survivors of Sexual Assault
13) Resolution 21- Mitigating the Transportation Barrier for Accessibility of Healthcare for the Medicaid Population
14) Resolution 27- Increased Access to Identification Cards for the Homeless Population
15) Resolution 42- Increasing Firearm Safety to Prevent Accidental Child Deaths
16) Resolution 47- Addressing the Need for Standard Evidenced-Based Screening Tools to Improve Care of Adolescent and Pediatric Patients with Depression

RECOMMENDED FOR REFERAL

17) Resolution 10- Increasing Access to Hearing Aids
18) Resolution 34- Tuition Reimbursement for Medical Student Performed Electronic Health Record Documentation as a part of Evaluation and Management

RECOMMENDED FOR NOT ADOPTION

19) Resolution 02- Permanent Reauthorization of the Children's Health Insurance Program
20) Resolution 04- Comprehensive Human Papillomavirus (HPV) and Vaccination Education in School Health Curricula
21) Resolution 05- Federal Legalization of Syringe Exchange Programs
22) Resolution 06- Pharmaceutical Advertising in Electronic Health Record Systems
23) Resolution 07- Support for Preregistration in Biomedical Research
24) Resolution 08- Support the Use of Evidence-Based Guidelines for Determining Liver Transplant Waiting Periods in Alcohol-Related Liver Disease
25) Resolution 09- Expansion of AMA Support of Trafficking Victims
26) Resolution 11- Improved Access to Eye Exams for Individuals with Diabetes
27) Resolution 12- Increasing Patient Access to Sexual Assault Nurse Examiners
28) Resolution 14- Regulating Front-of-Package Labels on Food Products
29) Resolution 17- Support of Supplemental Nutrition Assistance Program (SNAP) Education Programs and Research
30) Resolution 22- Research Models for Screening, Diagnosis, and Support Services for Children with Autism Spectrum Disorder
31) Resolution 23- Support for Very Low Nicotine Content Cigarettes as Part of the FDA's Cigarette Nicotine Reduction Plan
32) Resolution 25- Improving Minors' Access to Prenatal and Pregnancy-Related Care
33) Resolution 26- Limiting the Use of Restrictive Housing in Adult Correctional Facilities
34) Resolution 28- Improved Regulations on Electronic Nicotine Delivery Systems (ENDS) and Electronic Cigarettes
35) Resolution 29- Support for the Standardization of Driving Restriction Laws After Transient Loss of Consciousness
36) Resolution 31- Support the Use of Heroin Assisted Treatment Programs
37) Resolution 32- Decrease adolescent mortality through more comprehensive Graduated Driver Licensing programs
38) Resolution 33- Improving Support and Access for Medical Students with Disabilities
39) Resolution 35- Physician Use of Emergency Lights in Responding to Medical Emergencies
40) Resolution 36- Machine Intelligence and Data Science Literacy
41) Resolution 37- Opposition to Lack of Evidence Based Medicine in Drug Courts
42) Resolution 38- Equality for COMLEX & USMLE

43) Resolution 39- Support Mental Health Screenings for Detained Minority Youth
44) Resolution 40- Development and Implementation of Guidelines for responsible Media Coverage of Mass Shootings
45) Resolution 41- Reducing the Rate of Maternal Mortality in Black Mothers
46) Resolution 45- Expanding On-Site Physician Home Health Care to Low-Income Families and the Chronically Ill
47) Resolution 48- Health Services to Children of Incarcerated Parents
48) Resolution 49- Oversight of Programs for Physicians Who Do Not Match into Residency Programs
49) Resolution 51- Mandated Choice Organ Donation
50) Resolution 52- Encouraging Pharmaceutical Price Transparency at the Point of Sale
51) Resolution 53- Assessment of Civic and Healthcare Policy Literacy Among Medical Students
52) Resolution 54- Studying the Feasibility of a Potential Alternative Licensure Pathway for International Medical Graduates Who Have Completed International Graduate Medical Education
53) Resolution 55- Encourage the Reduction of Problematic Usage of Antipsychotic Medications in Nursing Homes
54) Resolution 56- Amendment by Addition to H-130.942, Development of a Federal Public Health Disaster Intervention Team
55) Resolution 57- Establishing Efficacy and Protocol for Implementing Patient-Specific 3D Printed Devices
56) Resolution 59- Capping Sperm Donation
57) Resolution 60- Virtual and Augmented Reality in Medical School Education

RECOMMENDED FOR REAFFIRMRATION

58) Resolution 24- Increasing Accessibility to Adult Incontinence Products
59) Resolution 30- 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
60) Resolution 43- Healthcare Finance in the Medical School Curriculum
61) Resolution 44- Promoting Awareness Regarding Teledermatology Services for Rural Populations
62) Resolution 50- Support for medical school community outreach programs focusing on health education and preventive services in student-run clinics
63) Resolution 58- Equal Parental Leave for Medical Students

In its review, your Reference Committee took into consideration the recommendations by your HCC on its “Reaffirmation Calendar.” Your Committee determined that reaffirming existing AMA policy falls outside the scope of Section Reference Committee’s authority. From here, your Committee assessed whether “formal support” would be an appropriate recommendation. Because “formal support” is not codified in your MSS IOP, your Committee did not find utility in its use. Consequently, your Committee determined that the most appropriate recommendation for any item placed

on the Reaffirmation Calendar due to existing AMA policy was “not adopt.” Your Committee determined that it was within its purview to reaffirm existing AMA-MSS policy, and items that were on the Reaffirmation Calendar due to exclusively existing AMA-MSS policy recommended as reaffirmations.

(1) RESOLUTION TASK FORCE REPORT 1- REFORMS TO THE RESOLUTION PROCESS: RECOMMENDATIONS FROM THE MSS RESOLUTION TASK FORCE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends the recommendations from Resolution Task Force Report A be adopted and the remainder of the report be filed.

Resolution Task Force Report A 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.

8. 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.
9. 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.
10. 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.
11. That the MSS improve transparency of resolution feedback among all actors throughout the resolution process by:
    a. Requiring the GRAF, MSS Council 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.

12. 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.
13. 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.
14. That the MSS reaffirm its existing process of creating the Assembly's Order of Business according to quantitative resolution scores.
15. 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.
16. 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.

Your Reference Committee received no testimony on this report. Your Reference Committee applauds the diligence of the Resolution Task Force and believes it adequately researched various avenues of Resolution review improvements.

For these reasons, your Reference Committee recommends the recommendations in the Resolution Task Force Report A be adopted and the remainder of the report be filed.

(2)COMMITTEE ON LONG RANGE PLANNING REPORT A- STUDY THE MOTIVATIONS BEHIND RESOLUTION WRITING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends the recommendation from the Committee on Long Range Planning Report A be adopted and the remainder of the report be filed.

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.

Your Reference Committee received no testimony on the Committee on Long Range Planning Report A. Your Reference Committee appreciates the detailed data presented by COLRP and acknowledges their expertise on this subject matter.

For these reasons, your Reference Committee recommends the recommendations in COLRP Report A be adopted and the remainder of the report be filed.

(3) RESOLUTION 20- ENCOURAGE FINAL EVALUATION REPORTS OF SECTION 1115 DEMONSTRATIONS AT THE END OF THE DEMONSTRATION CYCLE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 20 be adopted.

Resolution 20 asks 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.

Your Reference Committee received mixed testimony on this Resolution. Concern was noted regarding scope and feasibility. Further, it was noted that current AMA policy H-

290.897 Medicaid and State Children's Health Insurance Programs currently adopts the Centers for Medicare and Medicaid Services written guidelines. However, your Reference Committee believed it would valuable for the CMS to actively collect the data necessary to further support the GAO recommendations through the addition of this resolution.

For these reasons, your Reference Committee recommends Resolution 20 be adopted.

(4)RESOLUTION 46- DEVELOPING DIAGNOSTIC CRITERIA AND EVIDENCE-BASED TREATMENT OPTIONS FOR PROBLEMATIC PORNOGRAPHY VIEWING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 46 be adopted.

Resolution 46 asks that 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.

Your Reference Committee received supportive testimony for this resolution. Resolution 46 presented significant data and fills a distinct policy gap. Your Reference Committee additionally believed it appropriate for the AMA to support research.

For these reasons, your Reference Committee recommends Resolution 46 be adopted.

(5) GOVERNING COUNCIL REPORT A - PILOT IMPLEMENTATION OF THE 2018 RESOLUTION TASK FORCE RECOMMENDATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that GC Report A, Recommendation 8 be amended by deletion to read as follows:

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.~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that GC Report A Be adopted as amended, and the remainder of the report be filed.

GC Report A recommends (1) the implementation of a pilot based on the following reforms during the next cycle of the resolution process, and (2) 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.

Your Reference Committee received testimony largely in support of the recommendations. However, concern was noted by both Region 1 and an individual that 8b. limited the Assembly's ability to organically determine which resolutions require debate on the floor. Your Reference Committee echoed these concerns and believed the autonomy of the Assembly to regulate its own pace is vital to the policy adoption process.

For these reasons, your Reference Committee recommends that the recommendations from GC Report A be adopted as amended and the remainder of the report be filed.

(6) RESOLUTION 01- OPPOSITION TO REGULATIONS THAT PENALIZE IMMIGRANTS FOR ACCESSING HEALTH CARE SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 01 be amended by deletion to read as follows:

~~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~~

RECOMMENDATION B

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 01 be amended by addition and deletion to read as follows;

RESOLVED, That our AMA upon the release of and proposed rule or ~~make an immediate statement to oppose~~ regulations that would deter immigrants and/or their dependents from utilizing necessary health care services issue a formal comment expressing its opposition, and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 01 be amended by deletion to read as follows;

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

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 01 be amended by deletion as follows;

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

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the Resolution 01 be amended by addition as follows;

RESOLVED, That our AMA amend AMA policy H-20.901 by addition and deletion to read as follows:

HIV, Immigration, and Travel Restrictions- H-20.901

Our AMA: (1) supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649) provided such enforcement does not deter legal immigrants and/or their dependents from seeking needed health care; (2) recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (3) recommends that non- immigrant travel into the United States not be restricted because of HIV status; and (4) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that Resolution 01 be adopted as amended.

Resolution 01 asks that our AMA (1) amend H-290.983 by addition, to read as follows:

Support of Health Care to Legal Immigrants H-290.983

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.

(2) make an immediate statement to oppose regulations that would deter immigrants and/or their dependents from utilizing necessary health care services, encourage medical providers to participate in public comment periods regarding such regulations, and (3) that this resolution be forwarded immediately to the House of Delegates at A-18.

Your Reference Committee received mixed testimony on this resolution. Support was largely shown for the spirit of the resolution. With consideration of the MSS political capital at the House of Delegates, and sufficient current AMA policy to justify AMA opposition to the administrations potential charge proposal, your Reference Committee did not find justification to forward Resolution 01 immediately to the House of Delegates.

For these reasons, your Reference Committee recommends Resolution 01 be adopted as amended.

(7) RESOLUTION 03- EXPANSION OF FEDERAL GUN RESTRICTION LAWS TO INCLUDE DATING PARTNERS AND CONVICTED STALKERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 03 be amended by addition to read as follows:

RESOLVED, That our AMA-MSS 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.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 03 be adopted as amended.

Resolution 03 asks 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.

Your Reference Committee received supportive testimony for Resolution 03. In light of the CSAPH Report 4 which addresses this issue to the House, the authors offered an internal amendment. Your Reference Committee agreed with this amendment.

For these reasons, your Reference Committee recommends that Resolution 03 be adopted as amended.

(8) RESOLUTION 13- ADDRESSING STUDENT DEBT IN MEDICAL SCHOOL ATTRITION DUE TO MENTAL ILLNESS

RECOMMENDATION A:

Madam Speaker, Your Reference Committee recommends Resolution 13 be amended by addition and deletion to read as follows:

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 and/or physical illness

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends Resolution 13 be adopted as amended.

Resolution 13 asks 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.

Your Reference Committee received mixed testimony for this resolution. Region 3, MSS Committee on Medical Education, and the Massachusetts Delegation were in support of this resolution. Speaking in opposition, both Region 1 and an individual cited concerns of feasibility, as well as concerns with the data presented. Your Reference Committee noted that this resolution supports a study, which allows flexibility for policy-makers. Your Reference Committee found this issue well within the scope of the MSS and an important issue to medical students.

For these reasons, your Reference Committee recommends that Resolution 13 be adopted as amended.

(9) RESOLUTION 15- SUPPORT FOR CONTINUED 9-1-1 MODERNIZATION AND THE NATIONAL IMPLEMENTATION OF TEXT-TO-911 SERVICE

RECOMMENDATION A:

Madam Speaker, Your Reference Committee recommends the first Resolve of Resolution 15 be amended by deletion to read as follows

~~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~~

RECOMMENDATION B:

Madam Speaker, Your Reference Committee recommends the second Resolve of Resolution 15 be amended by deletion to read as follows

~~RESOLVED, That our AMA support upgrades of existing 9-1-1 infrastructure to include a national implementation of text-to-911 capability.~~

RECOMMENDATION C:

Madam Speaker, Your Reference Committee recommends Resolution 15 be amended by addition as follows:

RESOLVED, That our AMA support the funding of federal grant programs for the modernization of 9-1-1 infrastructure.

Resolution 15 asks that our AMA (1) encourage federal lawmakers to secure increased and consistent funding for the modernization of 9-1-1 infrastructure; and (2) support upgrades of existing 9-1-1 infrastructure to include a national implementation of text-to-911 capability.

Your Reference Committee received positive testimony for this resolution. The Massachusetts Delegation, Pennsylvania Delegation, Connecticut Delegation, and Region 1 were all in support of this resolution. Concern was noted that 9-1-1 infrastructure is largely a state, local, or regional concern, which is usually by various federal grant programs. In order to address these logistics, your Reference Committee recommended an amendment to “support for” these various federal programs.

For these reasons, your Reference Committee recommends that Resolution 15 be adopted as amended.

(10) RESOLUTION 16- OPPOSITION TO ARMED CAMPUSES

RECOMMENDATION A:

Madam Speaker, Your Reference Committee recommends Resolution 16 be amended by addition and deletion to read as follows

RESOLVED, That our AMA-MSS oppose ~~legislation and policies that would~~ an 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~~.

RECOMMENDATION B:

Madam Speaker, Your Reference Committee recommends Resolution 16 be adopted as amended.

Resolution 16 asks 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.

Your Reference Committee received significant testimony in support of the spirit of this resolution. Both Region 1 and Region 2 were in support of the resolution. Amendments were proposed to make the language more succinct by the Pennsylvania delegation. The authors testified approval of an amendment to make internal policy as Region 7 noted that HOD Res 402-A-18 Schools as Gun-Free Zones going to the House of Delegates at A-18 addresses the presence of guns on school campuses. As such, an amendment to make internal policy will allow the MSS to support HOD Res 402-A-18. Your Reference Committee agreed with the amendment to make Resolution 16 internal.

For these reasons, your Reference Committee recommends Resolution 16 be adopted as amended.

(11) RESOLUTION 18- INCREASING THE LEGAL AGE OF PURCHASING AMMUNITION AND FIREARMS FROM 18 TO 21

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommended that Resolution 18 be amended by addition and deletion to read as follows:

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~~ who are not veterans of the United States armed forces, Reserve, National Guard or Individual Ready Reserves.
> (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.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 18 be adopted as amended.

Resolution 18 asks 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.

Your Reference Committee received mixed testimony on this resolution. This resolution seeks to amend AMA policy on the use, possession, and purchase of firearms. At present, AMA supports the ban on possession of use of firearms by unsupervised youth under the age of 18. This resolution seeks to increase that age to 21. In addition, the resolution seeks to expand this AMA policy into the realm of purchasing from licensed and unlicensed dealers, and to establish AMA support for an age requirement for this activity, the age being 21. As to the purchase of guns, members raised concerns that the language as presented ought to consider an exemption for active military duty members or veterans. Your Committee believed removing of the language about the purchasing limitation would enhance the impact of this resolution and ameliorate concerns and barriers to implementation.

For these reasons, your Reference Committee recommends Resolution 18 be adopted as amended.

(12) RESOLUTION 19- SUPPORT OFFERING HIV POST EXPOSURE PROPHYLAXIS TO ALL SURVIVORS OF SEXUAL ASSAULT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 19 be amended by addition and deletion to read as follows:

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~~ survivors of sexual assault, that these ~~victims~~ survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 19 be adopted as amended.

Resolution 19 asks that our AMA (1) advocate for education of physicians about the effective use of Post-Exposure Prophylaxis for HIV and the US PEP Clinical Practice Guidelines, (2) support increased public education about the effective use of Post-Exposure Prophylaxis for HIV, and (3) 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.

Your Reference Committee received significant testimony in support of this resolution. Concern was noted regarding the need to specify the 72-hour time requirement for prophylaxis. However, your Reference Committee ultimately decided that prescriptive language was not needed, but rather implied in the term prophylaxis. Regions 5, Region 1, and the Massachusetts Delegation were in support as written. Your Reference Committee recommends an amendment to update the word ‘victims’ to ‘survivors’ of sexual assault in order to be consistent with existing policy.

For these reasons your Reference Committee recommends that Resolution 19 be adopted as amended.

(13) RESOLUTION 21- MITIGATING THE TRANSPORTATION BARRIER FOR ACCESSIBILITY OF HEALTHCARE FOR THE MEDICAID POPULATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends the first Resolve of Resolution 21 be amended by addition and deletion to read as follows:

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~~ research efforts to assess the utility and feasibility of state-funded support of Non-Emergency Medical Transportation programs.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 21 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA-MSS ~~oppose the authorization of any federally-granted state waivers to cut Medicaid transportation services~~ supports the maintenance of funding for transportation services in state Medicaid programs.

RECOMMENDATION C:

Madam Speaker your Reference Committee recommends that Resolution 21 be adopted as amended.

Resolution 21 asks 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 our AMA-MSS oppose the authorization of any federally-granted state waivers to cut Medicaid transportation services.

Your reference Committee received significant testimony in support of the spirit of the resolution. Region 1 noted concern for issues of safety of NEMT programs. The Minority Issues Committee noted a lack of clarity in the language and requested development of clearer strategies. The Massachusetts Delegation proposed amendments to improve clarify. Region 2 supported the resolution. Your Reference Committee agreed that as written, the language would require the AMA to automatically oppose any waiver that contained a cut to transportation services regardless of the proposed policy changes advance AMA interests. As such, your Reference Committee believes broadening the language of the second resolved and adopted the amendment proposed by Massachusetts Delegation for the first amendment.

For these reason, your Reference Committee recommends Resolution 21 be adopted as amended.

(14) RESOLUTION 27- INCREASED ACCESS TO IDENTIFICATION CARDS FOR THE HOMELESS POPULATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second resolved of Resolution 27 be amended by addition and deletion as follows:

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

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third resolved of Resolution 27 be amended by deletion as follows:

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

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 27 be adopted as amended.

Resolution 27 asks that our AMA recognize that among the homeless population, a lack of an identification card serves as a barrier to accessing medical care as well as fundamental services that support a healthy lifestyle, 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 promote legislation changes and policy initiatives focused on providing identification cards to homeless individuals without charge.

Your Reference Committee received significant testimony in support of the spirit of the resolution. The Massachusetts Delegation noted concern over the use of 'simplified' as it could allow for unintended consequences. The Pennsylvania Delegation noted that this aligns with AMA's aim to reduce barriers to care for underserved populations. Region 5 also noted that this addresses a need of the homeless population to access social services. Concern over issues of scope and feasibility of the AMA over the legislation of identification cards was noted in both the second and third resolved. Further H-160.961-*Caring for the Poor* and H-160.903 *Eradicating Homelessness* adequately addresses the asks of the third resolved. Your Reference Committee reflected these concerns with appropriate amendments.

For these reasons, your Reference Committee recommends that Resolution 27 be adopted as amended.

(15) RESOLUTION 42- INCREASING FIREARM SAFETY TO PREVENT ACCIDENTAL CHILD DEATHS

RECOMMENDATION A:

Madam Speaker your Reference Committee recommends the first resolved of Resolution 42 be amended by deletion to read as follows:

~~RESOLVED, That our American Medical Association (AMA) amend existing policy, Prevention of Firearm Accidents in Children H-145.990, by addition 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~~

RECOMMENDATION B:

Madam Speaker your Reference Committee recommends the second resolved of Resolution 42 be amended by deletion to read as follows:

~~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~~

RECOMMENDATION C:

Madam Speaker your Reference Committee recommends that the third resolved of Resolution 42 be amended by addition and deletion as follows:

RESOLVED, That our AMA advocate for ~~expansion of~~ enactment of Child Access Prevention (CAP) Laws ~~to~~ in all 50 states~~ or to a federal law.~~

RECOMMENDATION D:

Madam Speaker your Reference Committee recommends Resolution 42 be adopted as amended.

Resolution 42 asks that our American Medical Association (AMA) amend existing policy, Prevention of Firearm Accidents in Children H-145.990, by addition to read as follows:

(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;

Further, Resolution 42 asks that our (2) AMA advocate for increased funding for research on the benefits of firearm safety features such as loading indicators and magazine disconnects and (3) our AMA advocate for expansion of Child Access Prevention (CAP) Laws to all 50 states or to a federal law.

Your Reference Committee received mixed testimony on this resolution. Region 5 noted this aligns with the American Academy of Pediatrics policy. The Massachusetts Delegation opposed this resolution testifying that current policy adequately addressed the asks. Your Reference Committee agreed that the first and second resolved clauses were not markedly different to current policies *Prevention of Firearm Accidents in Children* H-145.990 and *Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care* H-145.975.However, your Reference

Committee recognizes Resolution 42 addresses a timely and important issue, particularly pertaining to Child Access Prevention (CAP) laws.

For these reasons, your Reference Committee recommends Resolution 42 be adopted as amended.

(16) RESOLUTION 47- ADDRESSING THE NEED FOR STANDARD EVIDENCED-BASED SCREENING TOOLS TO IMPROVE CARE OF ADOLESCENT AND PEDIATRIC PATIENTS WITH DEPRESSION

RECOMMENDATION A:

Madam Speaker your Reference Committee recommends that Resolution be amended by addition as follows:

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 in children less than 11 years old 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.

RECOMMENDATION B:

Madam Speaker your Reference Committee recommends that Resolution 47 be adopted as amended.

Resolution 47 asks 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.

Your Reference Committee received supportive testimony on this Resolution. Both Region 6 and the Massachusetts Delegation were in support. Your Reference Committee believes that this resolution addresses a novel concern. However, your Reference Committee believes to best reflect the data presented and to stay consistent with the latest cited research, the resolution was amended to specify children under the age of 11 years of age.

For these reasons, your Reference Committee recommends Resolution 47 be adopted as amended.

(17) RESOLUTION 10- INCREASING ACCESS TO HEARING AIDS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 10 be referred for study.

Resolution 10 asks 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.

Your Reference Committee received testimony in support of the spirit of this resolution. Testimony for your section Alternate Delegate noted that the MSS Committee on Economics and Quality in Medicine are currently working on a report in response to MSS Resolution 29-I-17 which is addressing the Medicare coverage of hearing aids. It was further noted that an AMA CMS Report 2015was in opposition to Medicare coverage of hearing aids. Your Reference Committee believes that before the Medical Student Section adopts policy in potential opposition to the House of Delegate, the subject should be thoroughly studied.

For these reasons, your Reference Committee recommends Resolution 10 be referred for study.

(18) RESOLUTION 34- TUITION REIMBURSEMENT FOR MEDICAL STUDENT PERFORMED ELECTRONIC HEALTH RECORD DOCUMENTATION AS A PART OF EVALUATION AND MANAGEMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 34 be referred for study.

Resolution 34 asks that our AMA (1) 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; (2) 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; (3) 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; (4) 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.

(5) 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 .

(6) 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.
<u>15. Our AMA will strongly advocate for tuition reimbursement for medical student performed electronic health record documentation as a part of Evaluation and Management.</u>

(7) 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

(8) 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.

that our AMA-MSS (9) 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.

(10) 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)

(11) 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)

(12) 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.

Your Reference Committee received mixed testimony on this resolution, with the majority of testimony in opposition. An individual noted HOD BOT Report 40-A-18 which discusses Medicare coverage of services provided by proctor medical students is in line with the asks of Resolution 34. The New York Delegation noted concern that incentivizing a billable process could potentially become a distraction while also acknowledging the potential tangible benefit of this resolution. Further, concern was noted from multiple individuals regarding payment incentives, and further unintentional consequences of the resolution including effects on clinical education. The Massachusetts Delegation noted the need for a more thorough legal analysis of

Resolution 34 prior to adopt of policy. Your Reference Committee acknowledges that this resolution presents both potential benefits and unintentional consequences of medical education. Your Reference Committee addition held reservations due to language specifically that as written it implies that CMS does permit tuition reimbursement which is incorrect. Ultimately, it is important that the Medical Student Section thoroughly understands full array of effects medical student compensation would have on medical education and clinical training before adopting policy. Your Reference Committee believed the MSS CME and CEQM could further research mechanisms of student payment, regulation of payment, and the potential effects incentives could have on clinical training.

For these reasons, your Reference Committee recommends that Resolution 34 be referred for study.

(19) RESOLUTION 02- PERMANENT REAUTHORIZATION OF THE CHILDREN'S HEALTH INSURANCE PROGRAM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 02 <u>not be adopted.</u>

Resolution 02 asks that the AMA support permanent authorization of the Children's Health Insurance Program (CHIP) and oppose any future lapse in federal funding.

Your Reference Committee received testimony in support of the spirit of this resolution, but with concerns. The Massachusetts Delegation noted concerns over conflicting language of both 'support' and 'oppose' which is difficult to enact. Additionally, as currently CHIP has already been reauthorized for 10 years, this policy is no longer timely. Further, your Reference Committee found current policy adequate in supporting CHIP without the addition of further policy, including policy H-185.948- Health Insurance for Children.

For these reasons, your Reference Committee recommends Resolution 02 not be adopted.

(20) RESOLUTION 04- COMPREHENSIVE HUMAN PAPILLOMAVIRUS (HPV) AND VACCINATION EDUCATION IN SCHOOL HEALTH CURRICULA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 04 <u>not be adopted</u>

Resolution 04 asks that our AMA-MSS will ask the AMA to amend policy D-170.995 with the insertion and deletion to read as follows:

<u>Comprehensive</u> Human Papillomavirus (HPV) Inclusion in ~~High~~ School <u>Health</u> 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 availability of the HPV vaccine at the Advisory Committee on Immunization Practices recommended age of vaccination of 11 to 12 years old.

Your Reference Committee received testimony in support of the spirit of this resolution. However with consideration of testimony by the Section Alternate Delegate indicating concerns of political capital at the HOD as the MSS is bringing forward Res 404 Emphasizing the Human Papillomavirus Vaccines as Anti-Cancer Prophylaxis for a Gender-Neutral Demographic at A-18. Further, your House Coordination Committee found this resolution as a reaffirmation. Your Reference Committee found this testimony compelling.

For these reasons, your Reference Committee recommends Resolution 04 be not adopted

(21) RESOLUTION 05- FEDERAL LEGALIZATION OF SYRINGE EXCHANGE PROGRAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 05 not be adopted

Resolution 05 asks that our AMA amend policy H-95.958 (Syringe and Needle Exchange Programs) with the addition as follows:

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.

Your Reference Committee received mixed testimony on this resolution. Your House Coordination Committee found this resolution to be a reaffirmation. Further, Region 1 noted that current AMA policy currently already adequately covers the issues of needle exchange programs and federal support for needle exchange programs, which are inherently coupled with syringe exchange programs.

For these reasons, your Reference Committee recommends Resolution 05 not be adopted.

(22) RESOLUTION 06- PHARMACEUTICAL ADVERTISING IN ELECTRONIC HEALTH RECORD SYSTEMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 06 not be adopted

Resolution 06 asks 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 that our AMA support legislation banning pharmaceutical advertising in electronic health record (EHR) systems.

Your Reference Committee received testimony in support of the spirit of this resolution, specifically the second resolved, but with concern for significant unintended consequences. The New York Delegation cited concern that removing advertising within EHR systems could negatively affect the cost of EHR systems and unduly burden smaller physician practices. The Massachusetts Delegation noted potential issues of First Amendment violation. Additionally, testimony noted that no data had been presented indicating the effect advertisements in the EHR had on prescription rates, quality of care, nor other important variables. While research exists evaluating the effect of advertisements on consumerism, your Reference Committee found this data too broad to be sufficient. Without research or data, your Reference Committee believed it is premature to adopt policy.

For these reasons, your Reference Committee recommends Resolution 06 not be adopted.

(23) RESOLUTION 07- SUPPORT FOR PREREGISTRATION IN BIOMEDICAL RESEARCH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 07 not be adopted

Resolution 07 asks that our AMA support practices that encourage preregistration of research studies in order to mitigate publication bias and improve the reproducibility of biomedical research.

Your Reference Committee received testimony in support of the spirit of this resolution. Amendments were proposed by the Massachusetts Delegation and Pennsylvania Delegation. Region 1 proposed an amendment to make Resolution 07 internal and noted concerns about the implications of this policy on current research opportunities. Your Reference Committee also noted HOD policy H-460.912- *Principles for Conduct and Reporting of Clinical Trials*, which explicitly states “that Our AMA…(5) encourages the expansion of clinical trial registrants to ClinicalTrials.gov” and “(6) ll Trials Registered; All

Results Reported" at Alltrials.net that supports the registration of all past, present and future clinical trials and the release of their summary reports." Further your reference committee believes further data is needed to adequately support the resolution beyond what current HOD policy encapsulates.

For these reasons, your Reference Committee recommends Resolution 07 be not adopted.

(24) RESOLUTION 08- SUPPORT THE USE OF EVIDENCE-BASED GUIDELINES FOR DETERMINING LIVER TRANSPLANT WAITING PERIODS IN ALCOHOL-RELATED LIVER DISEASE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 08 not be adopted

Resolution 08 asks 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 that our AMA supports the use of evidence-based guidelines for determining liver transplant waiting periods in alcohol-related liver disease.

Your Reference Committee received mixed testimony on this resolution. Multiple individuals testified noting concerns over language of the first Resolve. Region 1 stated testimony regarding concern about a lack of apparent expert input of this resolution. As written, the Resolves are inherently conflicting as they support both current and further guidelines when new guidelines may or may not align. Your Reference Committee was persuaded by testimony of Region 1 regarding lack of expert insight into this resolution, and further questioned the scope of the Medical Student Section authoring or adopting the resolution without pursuing expert opinion and study.

For these reasons, your Reference Committee recommends Resolution 08 not be adopted.

(25) RESOLUTION 09- EXPANSION OF AMA SUPPORT OF TRAFFICKING VICTIMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 09 not be adopted.

Resolution 09 asks 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.

Your Reference Committee received mixed testimony on this resolution. There was concern that this amendment is not a substantive amendment to current policy**.** Further HOD Res 15-A-18-Human Trafficking/Slavery Awareness will be presented to the HOD at A-18 which addressed the concerns of Resolution 09. Your Reference Committee fully supports the spirit of the resolution. However, with concern for the scope and expertise of the MSS, policy HOD Res 15-A-18, and current AMA policies adequately addressing the asks of the resolution your Reference Committee does not believe it would be in the best interest of MSS to bring forward another policy on human trafficking.

For these reasons, your Reference Committee recommends Resolution 09 not be adopted.

(26) RESOLUTION 11- IMPROVED ACCESS TO EYE EXAMS FOR INDIVIDUALS WITH DIABETES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 11 not be adopted.

Resolution 11 asks that our AMA encourage the use of diabetic retinopathy telescreening in primary care centers for patients with diabetes in underserved or remote locations.

Your Reference Committee the majority of testimony your Reference Committee received was in opposition to this resolution. Your Section Delegates testified that the American Diabetic Association differs in position stating that “telescreening is not a substitute for a comprehensive eye exam, which type 2 diabetics should have when first diagnosed and type 1 diabetics should have within 5 years of diagnosis”. Further, testimony regarding CMS Report 7-A-17 was found to adequately address the asks of the resolution.

For these reasons, your Reference Committee recommends that Resolution 11 be not adopted.

(27) RESOLUTION 12- INCREASING PATIENT ACCESS TO SEXUAL ASSAULT NURSE EXAMINERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 12 not be adopted

Resolution 12 asks 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.

Your Reference Committee received mixed testimony on this Resolution. Concern was noted that the resolution shifts autonomy away from the role of a physician. Further, testimony from Pennsylvania stated that the second Resolved could potentially bring forward issues involving the transfer of patients, and questioned the efficiency of this solution. Your Reference Committee found this testimony compelling. With the proposed amendment by the Pennsylvania Delegation to address these concerns, your Reference Committee found that current AMA policy H-80.999- Sexual Assault Survivors adequately covers the asks of this resolution stating that “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.”

For these reasons, your Reference Committee asks that Resolution 12 not be adopted.

(28) RESOLUTION 14- REGULATING FRONT-OF-PACKAGE LABELS ON FOOD PRODUCTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 14 not be adopted.

Resolution 14 asks 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 that our AMA support the use of front-of-package warning labels on foods that contain excess added sugar.

Your Reference Committee received mixed testimony for this resolution. As noted by the Massachusetts Delegation, AMA policy D-150.974- Support for Nutrition Label Revisions and FDA Review of Added Sugars supports nutrition labeling by the FDA including sugar. Your Reference Committee does not believe that as written this would further advance current efforts. Further, your Reference Committee found the language overly prescriptive.

For these reasons, your Reference Committee recommends that Resolution 14 not be adopted.

(29) RESOLUTION 17- SUPPORT OF SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) EDUCATION PROGRAMS AND RESEARCH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 17 not be adopted.

Resolution 17 asks 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, nutrient-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 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.

Your Reference Committee received mixed testimony on this resolution. The Massachusetts Delegation noted concern of the high fiscal note, and little data presented regarding the education programs associated with SNAP, which is heavily advocated for in this resolution. Concern that this resolution does not accurately address current discussions surrounding the Supplemental Nutrition Assistance Program was also noted. Region 1 found issues with overly prescriptive wording of the resolution and proposed that this resolution should be further developed. Your Reference Committee found this testimony convincing. Additionally, AMA HOD Res 233-A-18 titled Support for the Reauthorization of the Supplemental Nutrition Assistance Program, will be presented to the HOD at A-18. HOD Res 233 will therefore address the need for urgency cited by

the authors, to support SNAP prior to the new federal budget adoption. Your Reference Committee found this testimony convincing.

For these reasons, your Reference Committee recommends that Resolution 17 not be adopted.

(30) Resolution 22- RESEARCH MODELS FOR SCREENING, DIAGNOSIS, AND SUPPORT SERVICES FOR CHILDREN WITH AUTISM SPECTRUM DISORDER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 22 not be adopted.

Resolution 22 asks that our AMA support research models for screening, diagnosis, and support services for children with Autism Spectrum Disorder (ASD), and that our AMA advocate for increased funding for research models to ensure that children with ASD receive necessary interventions as early as possible.

Your Reference committee received testimony in support of the spirit of this resolution. However, your Reference Committee believed current AMA policies H-460.926- Funding of Biomedical, Translational, and Clinical Research and H-90.969- Early Intervention for Individuals with Developmental Delay adequately cover the asks of this resolution.

For these reasons, your Reference Committee recommends that resolution 22 not be adopted.

(31) RESOLUTION 23- SUPPORT FOR VERY LOW NICOTINE CONTENT CIGARETTES AS PART OF THE FDA'S CIGARETTE NICOTINE REDUCTION PLAN

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 23 not be adopted.

Resolution 23 asks 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.

Your Reference Committee received mixed testimony on this Resolution. It was noted that H-495.988- FDA Regulation of Tobacco Products already supports the FDA in its authority, required disclosure, and research of tobacco products. Your Reference Committee found that the ask of Resolution 23 is additionally inherently conflicting to the spirit of current AMA policy regarding tobacco usage. Further, your Reference Committee found the supporting data inadequate to develop a strong policy in support of the ask.

For these reasons your Reference Committee recommends Resolution 23 not be adopted.

(32) RESOLUTION 25- IMPROVING MINORS' ACCESS TO PRENATAL AND PREGNANCY RELATED CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 25 not be adopted.

Resolution 25 asks that (1) 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 (2) that our AMA amend existing AMA policy, H-420.978 Access to Prenatal Care, by addition 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

Your Reference Committee received testimony in support of the spirit of this resolution with proposed amendments. Your Reference Committee noted that Ethics Opinion 2.2.2- Confidential Health Care for Minors adequately addresses a minor's right to prenatal care. Furthermore, HOD Resolution 008- Health Care Rights of Pregnant Minors addresses the asks of the resolution and will be going to the HOD ad A-18. Your Reference Committee does not find it within the MSS's best interest to introduce a resolution of similar asks at the HOD at the Interim meeting.

For these reasons, your Reference Committee recommends that Resolution 25 not be adopted.

(33) RESOLUTION 26- LIMITING THE USE OF RESTRICTIVE HOUSING IN ADULT CORRECTIONAL FACILITIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 26 not be adopted.

Resolution 26 asks 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, support efforts to ensure that the mental and physical health of all individuals in restrictive housing are regularly monitored by health professionals, and support the development and use of safe alternatives to restrictive housing in adult correctional facilities.

Your Reference Committee received little testimony on this resolution, with Pennsylvania Delegation in support of the spirit of Resolution 26. Your Reference Committee noted that while the resolution utilized data from the National Commission on Correctional Health Care, the resolution did not take into account AMA's foundational role in the existence and guidelines created by the NCCHC, including the stance on solitary confinement. Your Reference Committee finds AMA's role in NCCHC's guidelines on solitary confinement an appropriate avenue for AMA to address solitary confinement and does not believe further policy will create substantive change, if any. It was further noted that MSS Res4-I-17 will be brought forward to the HOD at A-18 already addresses the issue of solitary confinement.

For these reasons, your Reference Committee recommends that Resolution 26 not be adopted.

(34) RESOLUTION 28- IMPROVED REGULATIONS ON ELECTRONIC NICOTINE DELIVERY SYSTEMS (ENDS) AND ELECTRONIC CIGARETTES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 28 not be adopted.

Resolution 28 asks that our AMA (1) acknowledge the known harms of electronic nicotine delivery systems, particularly their ineffectiveness as smoking cessation devices, and (2) encourage physicians to recommend alternative therapies for smoking-cessation, (3) work with federal agencies to discourage the promotion of electronic nicotine delivery systems both among adolescents and as smoking cessation devices (4) 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 ~~18~~ 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 (5) 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.

Your Reference Committee received mixed testimony for this resolution. An individual testified noting a report from AMA's Council on Science and Public Health being introduced at the HOD A-18 which addresses the asks of this resolution. Your Reference Committee believes it would be redundant for the Medical Student Section to advocate for a policy change in the House of Delegates considering AMA's Council on Science and Public Health report entitled "Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking" is being introduced at A-18. As resolution 28 is written externally with a proposed amendment, your Reference Committee does not believe it is well suited for an amendment that amends the asks to make it internal.

For these reasons your Reference Committee recommends that Resolution 28 not be adopted.

(35) RESOLUTION 29- SUPPORT FOR THE STANDARDIZATION OF DRIVING RESTRICTION LAWS AFTER TRANSIENT LOSS OF CONSCIOUSNESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 29 not be adopted.

Resolution 29 asks 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.

Your Reference Committee received mixed testimony on this resolution. While the spirit of the resolution was supported, current data was not found to be supportive enough to develop a strong policy position. Currently the American Academy of Neurology, as the leading experts, does not provide a set of recommendations for post-seizure driving. As such, your Reference Committee believed policy adoption and implementation prior to further study by experts in the field is premature.

For these reasons, your Reference Committee recommends Resolution 29 not be adopted.

(36) RESOLUTION 31- SUPPORT THE USE OF HEROIN ASSISTED TREATMENT PROGRAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 31 not be adopted.

Resolution 31 asks that our AMA (1) support the use of heroin-assisted treatment (HAT) programs for heroin-dependent patients and (2)remove policy H-55.991, Use of Heroin in Terminally Ill Cancer Patients With Severe Chronic Pain

Your Reference Committee received testimony in opposition to this resolution. Multiple concerns were brought forward including furthering the stigma for FDA-approved medications to treat substance use disorders, which already prevent some treatment. Further, it was noted that “HAT” as a solution is not discussed by the nation’s leading addiction medicine or public health experts; unless and until it gains any sort of traction there, it would be premature for AMA to lend its support. Additionally, the potential for any misunderstanding of AMA’s stance on heroin by the general public, health care and public health communities, policymakers and national stakeholders could have extremely negative consequences for the AMA as a whole and undo the strides made by the AMA Opioid Task Force to combat this epidemic. Lastly, as heroin is currently a schedule one drug, introducing it into a treatment program would require significant legal changes.

For these reason, your Reference Committee recommends that Resolution 31 not be adopted.

(37) RESOLUTION 32- DECREASE ADOLESCENT MORTALITY THROUGH MORE COMPREHENSIVE GRADUATED DRIVER LICENSING PROGRAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 32 not be adopted.

Resolution 32 asks our AMA to 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

Your Reference Committee received testimony in support of the spirit of this resolution. Concern was noted that increasing the driving age requirement in various states through standardization processes was overly restrictive. Region 1 proposed an amendment to eliminate “increasing.” Concern over scope of the MSS and itslack of expertise in this issue was also noted, . Additionally, HOD Resolution 426-A-18, Decrease Adolescent Mortality Through More Comprehensive Graduated Driver Licensing Programsaddresses this issue.

For these reasons, your Reference Committee recommends Resolution 32 not be adopted.

(38) RESOLUTION 33- IMPROVING SUPPORT AND ACCESS FOR MEDICAL STUDENTS WITH DISABILITIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 33 not be adopted.

Resolution 33 asks 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; 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 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).

Your Reference Committee received testimony in support of the spirit on this resolution. However, concern over the scope, feasibility, and purview of the AMA over the LCME was noted. Your Reference Committee additionally held concerns that this resolution would not have a substantial impact. As written, it is unclear how this resolution can be effectively executed. The language would additionally tie AMA policy to the policy of outside organizations, which greatly increases the potential for unintended consequences. Your Reference Committee found these concerns compelling.

For these reasons, your Reference Committee recommends Resolution 33 not be adopted.

(39) RESOLUTION 35- PHYSICIAN USE OF EMERGENCY LIGHTS IN RESPONDING TO MEDICAL EMERGENCIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 35 not be adopted.

Resolution 35 asks that our AMA encourage research on the effect of physician use of emergency lights in private vehicles when responding to medical emergencies, which should include effects on response time, patient outcomes and physician motor vehicle safety.

Your Reference Committee received mixed testimony on this resolution. Your Reference Committee noted concern over the lack of data available on this concept. Because of the national variability, your Reference Committee believes other organizations are more appropriate to conduct research on physician use of emergency lights.

For these reasons, your Reference Committee recommends Resolution 35 not be adopted.

(40) RESOLUTION 36- MACHINE INTELLIGENCE AND DATA SCIENCE LITERACY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 36 not be adopted.

Resolution 36 asks that our AMA-MSS promote physician data science literacy.

Your Reference Committee received mixed testimony on this resolution. The Whereas clauses of this resolution used evidence from both machine intelligence and data science inter-changeably, which does not accurately reflect the asks of the resolved. Region 1 testified in opposition due to vague language. The MSS Committee on Scientific Issues proposed an amendment to strike the first resolved due to reaffirmation to current policy H-485.003 title. Your Reference Committee found these testimonies compelling.

For these reasons, your Reference Committee recommends Resolution 36 not be adopted.

(41) Resolution 37- Opposition to Lack of Evidence Based Medicine in Drug Courts

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 37 not be adopted.

Resolution 37 asks (1) that our AMA oppose court-mandated, specific treatment requirements for defendants without appropriate physician guidance and that (2) our AMA recommend the creation of guidelines for the judge-pharmaceutical company relationship that are aligned with current physician guidelines

Your Reference Committee received mixed testimony for this resolution.
Due to significant testimony in opposition to the resolution due to feasibility and scope, as well as the ethics mandated treatment, the authors of this resolution proposed an amendment. However, your Reference Committee found the amended language to be a reaffirmation of H-100.955 Support for Drug Courts, H-95.956 Harm Reduction Through Addiction Treatment, 9.7.2 *C*ourt-Initiated Medical Treatment in Criminal Cases*.* Your Reference Committee noted issues of scope and feasibility given the limited expertise of the MSS on this issue.

For these reasons, your Reference Committee recommends Resolution 37 not be adopted

(42) RESOLUTION 38- EQUALITY FOR COMLEX & USMLE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 38 not be adopted.

Resolution 38 asks that (1) our AMA ensure equal acceptance of the USMLE and COMLEX at all United States residency programs; (2) 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 and that 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.

Your Reference Committee received testimony in support of this resolution. While not mentioned in the resolution, National Board of Osteopathic Medical Examiners announced that beginning in September 2018, COMLEX-USA is transitioning to a new contemporary, two-decision point, competency-based examination blueprint and evidence-based design informed by extensive research on actual osteopathic physician practice, expert consensus, and NBOME National Faculty and stakeholder surveys. Your Reference Committee noted the resolution is not feasible as written, as the AMA is unable to 'ensure' 'equal acceptance'. Your Reference Committee had concern over purview and scope of accreditation processes. Additionally, your Reference Committee noted that H-310.909 ACGME Residency Program Entry Requirements adequately addresses AMA's position on the equality of COMLEX and USMLE scoring procedures.

For these reasons, your Reference Committee recommends Resolution 38 not be adopted.

(43) RESOLUTION 39- SUPPORT MENTAL HEALTH SCREENINGS FOR DETAINED MINORITY YOUTH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 39 not be adopted.

Resolution 39 asks that our AMA-MSS (1) support equal and appropriate mental health referrals in the detained minority youth population;(2) 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 (3) that our AMA-MSS support focused funding on research and regular evaluations to decrease disparities in mental health screening protocols at juvenile detention centers.

Your Reference Committee received mixed testimony for this resolution. Loyola University noted that more evidence was needed to better illustrate a discrepancy between care received by incarcerated minority youth and non-minority youth. Your Reference Committee agreed with this testimony. Further, concern over implementation and the ethics of mandatory, rather than volunteer, mental health screenings were noted. Your Reference Committee additionally found policies H-430.986- Health Care

While Incarcerated, H-60.919- Juvenile Justice System Reform, H-60.986- Health Status of Detained and Incarcerated Youth, and D-430.997 Support for Health Care Services to Incarcerated Persons to adequately cover the asks of this resolution. As this is covered in AMA policy and the MSS does not hold expertise in fields directly related to or involved in the mental health of detained minority youth, MSS-specific policy is redundant.

For these reasons, your Reference Committee recommends Resolution 39 not be adopted.

(44) RESOLUTION 40- DEVELOPMENT AND IMPLEMENTATION OF GUIDELINES FOR RESPONSIBLE MEDIA COVERAGE OF MASS SHOOTINGS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 40 not be adopted.

Resolution 40 asks 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 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.

Your Reference Committee received mixed testimony for this resolution. The California Delegation proposed amendments to strike the first resolved. While your Reference Committee finds this resolution timely and extremely important, we did not find the AMA as the appropriate organization to address the media coverage of mass shootings cases. Further, a lack of evidence over the correct way to address crisis public health issues within the media was noted as a concern. Lastly, your Reference Committee noted the high fiscal note associated with this resolution. Ultimately, your Reference Committee concluded that this resolution was not in the scope of the AMA nor feasible for the AMA to execute.

For these reasons, your Reference Committee recommends Resolution 40 not be adopted.

(45) RESOLUTION 41- REDUCING THE RATE OF MATERNAL MORTALITY IN BLACK MOTHERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that resolution 41 not be adopted.

Resolution 41 asks that (1) 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 (2) 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.

Your Reference Committee received mixed testimony for this resolution. While the spirit of the resolution was supported, the House Coordination Committee recommended Resolution 41 to be placed on the reaffirmation calendar due to policy D-402.993 Disparities and Maternal Mortality. Further, the Woman's Physician Section will be bring HOD Res-417 to A-18 which addresses the asks of this resolution It was also noted that the CDC, in conjunction with ACOG and The Alliance for Innovation in Maternal Health (AIM), are currently actively working to end disparities in maternal mortality rate- an initiative that was prompted by the AMA. For these reasons, your Reference Committee did not believe the current policy adequately addresses the asks of the resolution and the addition of further policy will not have any further impact. Your Reference Committee encourages the authors to utilize a Governing Council Action Item to address the ongoing work of closing disparities in maternal mortality.

For these reasons, your Reference Committee recommends Resolution 41 not be adopted.

(46) RESOLUTION 45- EXPANDING ON-SITE PHYSICIAN HOME HEALTH CARE TO LOW-INCOME FAMILIES AND THE CHRONICALLY ILL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 45 <u>not be adopted</u>

Resolution 45 asks 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 <u>or low-income</u> 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 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.

Your Reference Committee received supportive testimony of this resolution. Concerns over unintended consequences due to lack of clarity were noted by the Region 1 and the Massachusetts Delegation. The Medical Society of Maryland and the Committee on Economics and Quality in Medicine were both in support of Resolution 45. It was additionally noted that HOD Resolution 115-A-18 Expanding On-Site Physician Home Health Care to Low-Income Families and the Chronically Ill addresses the primary ask of Resolution 45. Your Reference Committee, with noted concerns for clarity with the current language of Resolution 45, did not believe it would be in MSS' best interest to present a duplicative resolution subject to the House of Delegates at I-18.

For these reasons, your Reference Committee recommends Resolution 45 not be adopted.

(47) RESOLUTION 48- HEALTH SERVICES TO CHILDREN OF INCARCERATED PARENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that resolution 48 not be adopted.

Resolution 48 asks that our AMA recognize the unique challenges facing children who are growing up with one or both parents in prison and 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.

Your Reference Committee received mixed testimony on this resolution.it was noted that in the fall of 2018 National Longitudinal Study of Adolescent to Adult Health will be releasing an updated report on the impact an incarcerated parent on childhood well-being. The Massachusetts Delegation testified in opposition citing issues of scope. Concern was further noted over feasibility as the current language is extremely broad. Your Reference Committee found this testimony compelling. Your Reference Committee also believed that it would be premature for the AMA to be supporting legislation prior to the 2018 report.

For these reasons, your Reference Committee recommends Resolution 48 not be adopted.

(48) RESOLUTION 49- OVERSIGHT OF PROGRAMS FOR PHYSICIANS WHO DO NOT MATCH INTO RESIDENCY PROGRAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that resolution 49 not be adopted.

Resolution 49 asks that our AMA (1) 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; (2) 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; and (3) 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.

Your Reference Committee received mixed testimony on this resolution. Regions 2, Region 3, the Connecticut Delegation, and the Massachusetts Delegation all proposed amendments to Resolution 49 due to lack of clarity. Concern was noted with unintentional consequences of language, such as “to ensure”, “aforementioned”, that leave the policy not actionable. Further, your Reference Committee noted the inherent conflict with opposing alternative licensing pathways and creating licensing pathways for medical students that do not match into residency. While the Reference Committee

applauds the authors on addressing an important issue, this resolution requires further policy refinement.

For these reasons, your Reference Committee recommends Resolution 49 not be adopted.

(49) RESOLUTION 51- MANDATED CHOICE ORGAN DONATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that resolution 51 not be adopted.

Resolution 51 asks that our AMA-MSS (1) 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, 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 and (2) supports creating a nationwide website to give individuals information about organ donation to educate citizens so they make an informed decision.

Your Reference Committee received testimony largely in opposition to this resolution. Region 1 noted concerns regarding effectiveness, feasibility, and insufficient evidence. Region 4 opposed Resolution 51 due to ethical considerations. The Massachusetts Delegation noted that the AMA already has a policy on studying the asks of Resolution 51 in place. Your Reference Committee found this testimony compelling.

For these reasons, your Reference Committee recommends Resolution 51 not be adopted.

(50) RESOLUTION 52- ENCOURAGING PHARMACEUTICAL PRICE TRANSPARENCY AT THE POINT OF SALE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that resolution 52 not be adopted.

Resolution 52 asks that our AMA encourage pharmacies to provide unsolicited information on cost-reducing programs to patients prior to distributing medication and that our AMA reaffirm the development of additional cost-reducing programs for patient medication.

Your Reference Committee received mixed testimony on this resolution. Massachusetts Delegation noted a lack of evidence of effectiveness of cost-reducing programs and concerns of scope in relation to pharmaceuticals. Region 6 was in support of the spirit of the resolution, with proposed amendments due to issues of clarity and concerns of purview. Furthermore, it was noted that the AMA Board of Trustees is expected to

present an I-18 report on the TruthinRx campaign, which focuses on many concerns raised in Resolution 52, including drug-price transparency. As such, your Reference Committee did not find this resolution will further assist AMA's current endeavors beyond the campaign and BOT report.

For these reasons, your Reference Committee recommends Resolution 52 not be adopted.

(51) RESOLUTION 53- ASSESSMENT OF CIVIC AND HEALTHCARE POLICY LITERACY AMONG MEDICAL STUDENTS.

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that resolution 53 not be adopted.

Resolution 53 asks that our AMA-MSS support a periodic formal assessment of civic and healthcare policy literacy among US medical students.

Your Reference Committee received mixed testimony on this resolution. Testimony stated that resolution 53 was better suited to the purview of LCME and other accreditation institutions. Additionally, concern was noted regarding feasibility due to vague language. Your Reference Committee additionally had concerns that formal assessments of medical student education would increase the burden on medical students and medical education requirements, particularly as policy and advocacy knowledge is not a requirement of physicians.

For these reasons, your Reference Committee recommends Resolution 53 not be adopted.

(52) RESOLUTION 54- STUDYING THE FEASIBILITY OF A POTENTIAL ALTERNATIVE LICENSURE PATHWAY FOR INTERNATIONAL MEDICAL GRADUATES WHO HAVE COMPLETED INTERNATIONAL GRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 54 not be adopted.

Resolution 54 asks that our AMA (1) support investigation into the demographics of international medical graduates who have completed prior international graduate medical education in residency programs in the United States, (2) 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 (3) study the feasibility of implementation of an alternative licensure pathway for international medical graduates who have completed prior international graduate medical education.

Your Reference Committee received mixed testimony on this resolution. The Massachusetts Delegation and individuals expressed concern that the language required clarity to avoid misinterpretation or unintended consequences. While the spirit of this resolution was applauded by the Reference Committee, your Reference Committee did not find the MSS to be the appropriate party to address this issue within the HOD and agreed with concerns about potential unintended consequences for medical students.

For these reasons, your Reference Committee recommends Resolution 54 not be adopted.

(53) RESOLUTION 55- ENCOURAGE THE REDUCTION OF PROBLEMATIC USAGE OF ANTIPSYCHOTIC MEDICATIONS IN NURSING HOMES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that resolution 55 not be adopted.

Resolution 55 asks that AMA amend 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) 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.

Your Reference Committee received testimony in opposition to Resolution 55. The Massachusetts Delegation opposed Resolution 55 as it did not find the resolution substantially different from current AMA policy. Additionally. it noted a high fiscal note requirement. Your Reference Committee agreed that the suggested amendment would fail to substantially alter current policy.

For these reasons, your Reference Committee recommends Resolution 55 not be adopted.

(54) RESOLUTION 56- AMENDMENT BY ADDITION TO H-130.942, DEVELOPMENT OF A FEDERAL PUBLIC HEALTH DISASTER INTERVENTION TEAM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that resolution 56 not be adopted.

Resolution 56 asks 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).
>
> 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.
>
> <u>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.</u>

Your Reference Committee noted that AMA Policy H-130.943 is to be sunset per AMA CSAPH A-18 Sunset Report, citing that the “Center on Public Health Preparedness and

Disaster Response" is no longer operational. Resolution 56 will therefore not be actionable at I-18.

For these reasons, your Reference Committee recommends Resolution 56 not be adopted.

(55) RESOLUTION 57- ESTABLISHING EFFICACY AND PROTOCOL FOR IMPLEMENTING PATIENT-SPECIFIC 3D PRINTED DEVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that resolution 57 not be adopted.

Resolution 57 asks that our AMA (1) support research into the efficacy of patient-specific devices and models that are designed and printed, by or under physician supervision, and (2) advocate for the education of physicians and the public about the availability and efficacy of 3D printed devices.

Your Reference Committee received mixed testimony for Resolution 57. Both Region 3 and the Texas Delegation were in support of the resolution as written. Region 1 expressed concerns that as the resolution addressed specific technologies, it would likely not stay up-to-date with scientific field advancement. More research references were requested to evaluate the safety of the field before AMA advocates for use of 3D printing. Your Reference Committee additionally noted the first resolved is currently covered under D-165.999 The Impact of Rapidly Developing Biotechnology on the Delivery of Medical Care which states "Our AMA Council on Medical Service will continue to study and report on the impact of technological developments on the practice of medicine..." and H-460.943- Potential Impact of Health System Reform Legislative Reform Proposals on Biomedical Research and Clinical Investigation stating that our AMA has Strong support and funding for...training and experience in, and participate in…; Strong financial and policy support for all aspects of biomedical science and research…; and Support and funding for evaluation and implementation research, including...technology assessment, medical device review..." Lastly, the second Resolved was found to be too broad of an ask with both "availability and efficacy" required.

For these reasons, your Reference Committee recommends Resolution 57 not be adopted

(56) RESOLUTION 59- CAPPING SPERM DONATION

RECOMMENDATION:

Madam Speaker your Reference Committee recommends that Resolution 59 not be adopted.

Resolution 59 asks that our AMA draft and advocate for legislation which limits the number of offspring that one sperm donor can have to 25.

Your Reference Committee received testimony in opposition to this resolution. Region 1noted insufficient evidence presented to support need for this policy and that a cap of 25 donations does not align with evidence-based research. Massachusetts Delegation was in opposition due to a high fiscal note in combination with a lack of evidence. Additionally, concern was noted that the subject matter of limiting gamete donation was not within the scope of the AMA and other organizations would be more appropriate in offering legislation.

For these reasons, your Reference Committee recommends Resolution 59 not adopted.

(57) RESOLUTION 60- VIRTUAL AND AUGMENTED REALITY IN MEDICAL SCHOOL EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 60 not be adopted.

Resolution 60 asks that our AMA (1) encourages medical schools to provide student access to VR/AR research opportunities and resources, including VR gear and software development platforms, encourages medical students to attend VR/AR conferences and interact with students in engineering, computer science, and other related fields, (2) 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 (3) 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.

Your Reference Committee received testimony in opposition to Resolution 60. It was noted that AMA-MSS is not the appropriate body to address these asks. The Massachusetts Delegation testified that these asks fall within the purview of accreditation organizations such as LCME. Region 4 noted that it is not within the purview of MSS to dictate medical student research participation. Region 1 cited AMA policy H-295.868- Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training and D-295.330 Update on the Uses of Simulation in Medical Education sufficiently addressing the asks of this resolution. It was also noted that HOD Res 317- Emerging Technologies (Robotics and AI) in Medical School Education will be brought to the HOD at A-18. Further, your Reference Committee noted concern that this policy could encourage disparities between medical schools in terms of medical education and general financial impact.

For these reasons, your Reference Committee recommends Resolution 60 not be adopted.

(58) RESOLUTION 24- INCREASING ACCESSIBILITY TO ADULT INCONTINENCE PRODUCTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that MSS Policy 245.021MSS be reaffirmed in lieu of Resolution 24.

Resolution 24 asks that our AMA advocate for legislation that removes sales tax on adult incontinence products and that our AMA encourages Medicare coverage for adult incontinence products.

Your Reference Committee received mixed testimony for Resolution 24. Concern by both Massachusetts Delegation and the New York Delegation for the high fiscal note was noted. The House Coordination Committee found this to be a reaffirmation to The Diaper Gap 245.021MSS which will be brought to the HOD at I-18.Your Reference Committee found this testimony to be compelling.

For these reasons, your Reference Committee recommends that MSS Policy 245.021MSS be reaffirmed in lieu of Resolution 24.

(59) RESOLUTION 30- 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

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that MSS Policy 250.020MSS be reaffirmed in lieu of Resolution 30.

250.020MSS Refugee Health Care:
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)

Resolution 30 asks 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;

Your Reference Committee received unanimous support of this resolution. However, the House Coordination Committee noted that current policies, and specifically the second resolved of 250.020MSS- Refugee Health Care, adequately satisfies the asks of this resolution stating that the AMA-MSS “encourage the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.” Your Reference Committee agreed with the House Coordination Committee.

For these reasons, your Reference Committee recommends Resolution 30 MSS Policy 250.020MSS be reaffirmed in lieu of Resolution 30.

(60) RESOLUTION 43- HEALTHCARE FINANCE IN MEDICAL SCHOOL CURRICULUM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that MSS Policy 630.011MSS be reaffirmed in lieu of Resolution 43

630.011MSS Improved Access and Programming of Non Scientific Issues in Medicine:

AMA-MSS will: (1) explore better methods of disseminating information from the AMA MSS to local chapters with the goals of increased access, and program development; and (2) develop a series of modular programs, which can be used by local chapters to educate their members on topics of importance to future physicians, according to the following guidelines: (a) the information must be flexible, dynamic, accessible and cost effective; (b) a variety of topics could be covered, including medical ethics, legal issues in medicine, the lifestyles of various specialties, medicine and the media, medical economics, etc. (MSS Res 14, I 88) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

Resolution 43 asks that our AMA-MSS (1) 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 (2) 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.

Your Reference Committee received mixed testimony on this Resolution with several suggested amendments. The House Coordination Committee recommended Resolution 43 for reaffirmation due to AMA policy D-295.321 *Healthcare Economics Education.* Additionally, MSS Policy 630.011- I*mproved Access and Programming of Non-Scientific Issues in Medicine*, was found adequate in addressing the concerns of this resolution. Your Reference Committee found this compelling. Your Reference Committee additionally noted that this resolution was beyond the scope of the AMA-MSS.

For these reasons, your Reference Committee recommends that MSS Policy 630.011MSS be reaffirmed in lieu of Resolution 43.

(61) RESOLUTION 44- PROMOTING AWARENESS REGARDING TELEDERMATOLOGY SERVICES FOR RURAL POPULATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that MSS Policy 440.012MSS be reaffirmed in lieu of Resolution 44

440.012MSS Public Education Announcements for Detection of Skin Cancer:

AMA-MSS will ask the AMA to support a public service announcement to increase public awareness of the high incidence of skin cancer, complications of

skin cancer and how to do home screening and routine self-exams for the early detection of skin cancer. (MSS Res 23, A-98) (Existing Policy Reaffirmed in Lieu of AMA Res 406, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

Resolution 44 asks 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.

Your Reference Committee received testimony in opposition of the resolution. The Connecticut Delegation testified in opposition, noting concerns about potential for poor use of funds in comparison to the impact of the resolution. An individual testified concern regarding the effectiveness of preventing skin cancer of this resolution. The House Coordination Committee recommended this as a reaffirmation due to MSS Policy 440.012MSS- *Public Education Announcement for Detection of Skin Cancer*. Your Reference Committee found this testimony compelling.

For these reasons, your Reference Committee recommends that MSS Policy 440.012MSS be reaffirmed in lieu of Resolution 44.

(62) RESOLUTION 50- SUPPORT FOR MEDICAL SCHOOL COMMUNITY OUTREACH PROGRAMS FOCUSING ON HEALTH EDUCATION AND PREVENTIVE SERVICES IN STUDENT-RUN CLINICS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that MSS Policies 160.001MSS and 106.004MSS be reaffirmed in lieu of Resolution 50.

160.001MSS: Support of Community Health Clinics with Student Involvement:

AMA-MSS will ask the AMA to: (1) endorse the efforts of existing community health clinics with student involvement offering minimal cost, quality primary care; and (2) encourage county and state medical societies to work with medical universities, private practitioners, local health departments, and regional charities to develop more community health clinics of this orientation. (AMA Res 76, A-82 Not 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)

160.004MSS Support for Free Clinics:

AMA-MSS encourages medical students to propose the establishment of free clinics in their own communities or volunteer their time to existing free clinics. (MSS Sub Res 18, I 91) (Reaffirmed: MSS Rep B, I-00)

(Reaffirmed: MSS Rep C, A-04) (Reaffirmed: MSS Rep E, I-05)
(Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Resolution 50 asks 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.

The House Coordination Committee recommended Resolution 50 to be placed on the reaffirmation calendar. Region 1 stated that this resolution, despite accurately highlighting the important role student-run clinics can play in undergraduate medical education and the community, fails to advance standing AMA-MSS policy, such as 160.001MSS- *Support of Community Health Clinics with Student Involvement* and 160.004MSS- *Support for Free Clinics*, that aims to promote participation in student-run clinics. Further, the lack of congruency between the arguments in the Whereas clauses and the Resolve clause weakens this resolution beyond its redundancy of current AMA-MSS policy.

For these reasons, your Reference Committee recommends MSS Policies 160.001MSS and 106.004MSS be reaffirmed in lieu of Resolution 50.

(63) RESOLUTION 58- EQUAL PARENTAL LEAVE FOR MEDICAL STUDENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that MSS Policy 310.049MSS be reaffirmed in lieu of Resolution 58

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)

Resolution 58 asks 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, encourages flexibility in medical school rotations and residency training programs, incorporating parental leave and alternative schedules for pregnant house staff and students, and 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.

Your Reference Committee received testimony in opposition to Resolution 58. Your Section Delegates noted that this resolution is within the purview of accreditation organizations such as LCME. Both Region 1 and the Massachusetts Delegation noted that current policy adequately covers the asks of Resolution 58. The Reference Committee agreed that MSS policy 310.049MSS- Equal Paternal and Maternal Leave for Medical Residents encapsulates the asks of this resolution internally.

For these reasons, your Reference Committee recommends MSS Policy 310.049MSS be reaffirmed in lieu of Resolution 58

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